

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 00501		BALTIMORE CITY HEALTH DEPARTMENT	
1. NAME OF DECEASED (Type or Print) <b>CASPAR C GOLDBECK</b>		2. DATE AND HOUR OF DEATH <b>1/13/69</b> <span style="float: right;">4 A M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>4 Union Memorial Hosp</b>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>226 MURDOCK RD</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>4 Union Memorial Hosp</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/10/91</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Campbell Soup Co.</b>	9. AGE (In years last birthday) <b>77</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HENRY GOLDBECK</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH HARBECK</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>151-01-0838</b>	17. INFORMANT <b>Mrs. Ruth M. Goldbeck</b>
		ADDRESS <b>Same</b>	
18. CAUSE OF DEATH			
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p><b>I</b></p> <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b></p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 35%;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>			
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p><b>(A) IMMEDIATE CAUSE</b> <b>CHRONIC OBSTRUCTIVE</b></p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p><b>(B) LUNG DISEASE</b></p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p><b>(C)</b></p> </div> <div style="width: 35%;"></div> </div>			
<p style="text-align: center;"><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>No</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1/4</b> 19 <b>69</b> to <b>1/13</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>1/12</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>W. H. Oehlert MD</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <b>1/13/69</b>
23C. PHYSICIAN'S NAME (Type) <b>WILLIAM H. OEHLERT MD</b>		23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1-16-69</b>	24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 16 1969</b>		25B. NAME OF REGISTRAR <b>James E. Johnson</b>	25C. FUNERAL DIRECTOR ADDRESS <b>Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md.</b>

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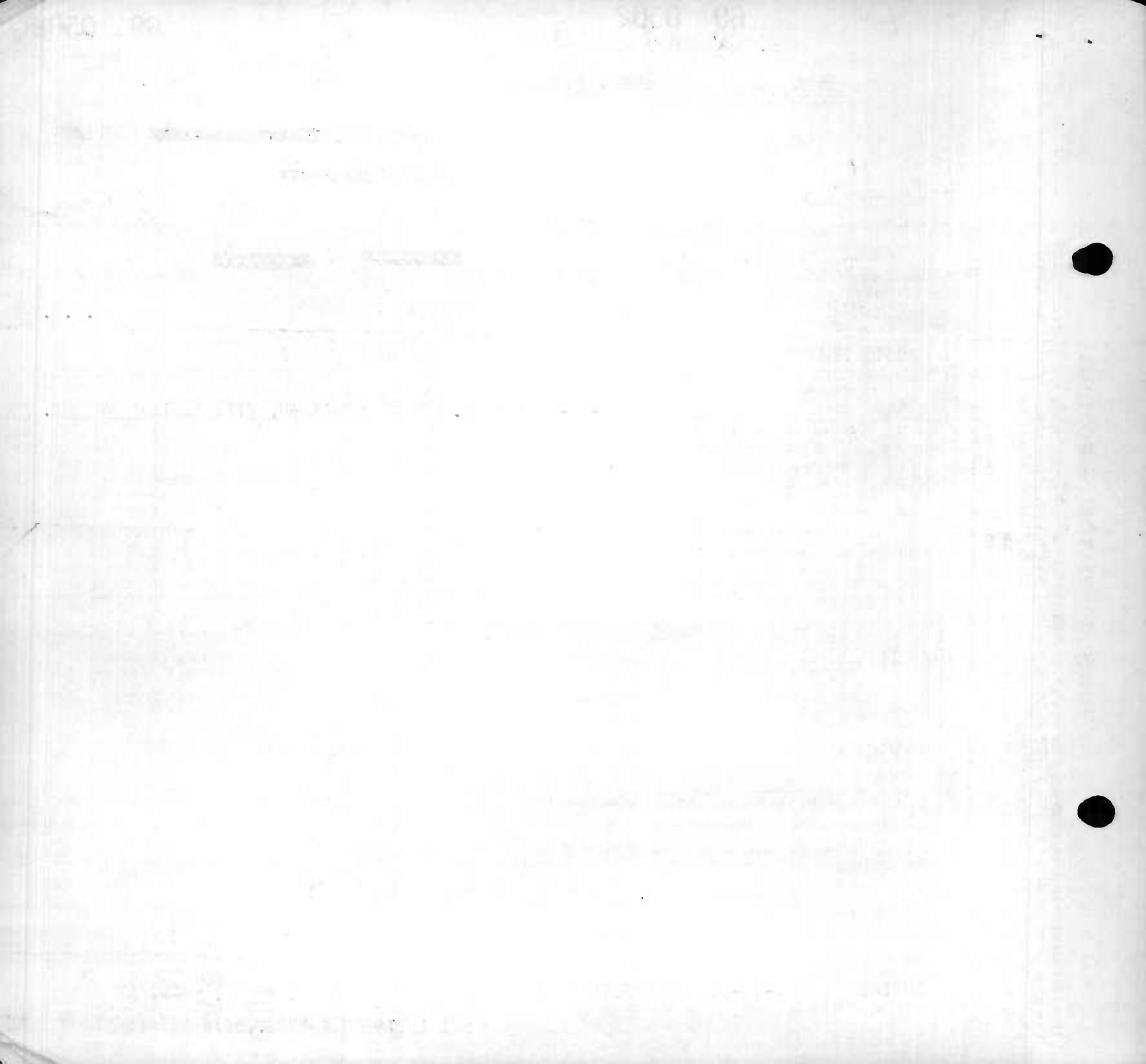
1963



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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>69 0502</b>
<div style="font-size: 2em; font-weight: bold;">345</div> <div style="font-size: 1.5em; font-weight: bold;">69 0502</div> <div style="font-size: 1.2em; font-weight: bold;">NEEDALMAN</div>		CERTIFICATE OF DEATH		
BIRTH NO.		M.		
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
<del>XXXXXXXXXX</del>		JENNIE 10am 1-13-69		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 Sinai Hospital</b>		A. STATE <del>XXXXXXXXXX</del> MARYLAND		
(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		B. COUNTY		
		C. CITY OR TOWN <b>BALTIMORE</b>		
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER <b>2112 WESTERN RUN DRIVE 27-55</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>W HITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <del>XXXXXXXXXX</del>	9. AGE (In years lost birthday) <b>89</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>
13. FATHER'S NAME <b>MEYER SHARFF</b>		14. MOTHER'S MAIDEN NAME <b>ROZEL ?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-32-5191 A</b>		17. INFORMANT <b>MR. HYMAN NEEDALMAN, 2112 WESTERN RUN DR. #9</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>411.9 + 230.9</b>		CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>cardiovascular shock</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>coronary insufficiency and congestion</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>heart failure</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Diabetes mellitus, chronic bronchitis</u>				
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 19__ to 19__, that (I) (we) lost saw the deceased alive on 1-13-69 19__ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Gian Caggiano MD.</b>		23B. DATE SIGNED <b>1-13-69</b>		23C. PHYSICIAN'S NAME (Type) <b>GIAN CAGGIANO</b>
23D. ADDRESS <b>SINAI HOSP, BALTO MD.</b>		23E. ADDRESS <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>1-14-69</b>	24C. NAME OF CEMETERY or CREMATORY <b>KNESSETH ISRAEL KOLK WOLYN</b>	24D. LOCATION (City, town, or county) (State) <b>R BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 14 1969</b>	25B. NAME OF REGISTRAR <b>Robert E. Talbot</b>	25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>		



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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 0503
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ISRAEL B. JACOBSON</b>		2. DATE AND HOUR OF DEATH <b>1/13/69</b> <b>8:45 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>Sinai Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>6108 GIST AVE. #21215</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>[REDACTED]</b>	9. AGE (In years last birthday) <b>86</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INSURANCE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>EXECUTIVE</b>		11. BIRTHPLACE (State or foreign country) <b>LITHUANIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-01-6323A</b>		17. INFORMANT <b>MRS. ANNA JACOBSON, 6108 GIST AVENUE #21215</b>	
18. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <b>coronary vasc. accid.</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>upper GI bleeding</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>ASCVD chronic brain syndrome</b>			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If In Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/29 1968</b> to <b>1/13 1969</b> , that (I) (we) last saw the deceased alive on <b>1/13 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <b>(did)</b> (did not) view the body after death.					
23A. SIGNATURE <b>Gerald B. Feldman MD</b>		23B. ADDRESS <b>Sinai Hosp.</b>		23C. DATE SIGNED <b>1/13/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>GERALD B. FELDMAN MD</b>		23D. ADDRESS <b>Sinai Hosp.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-14-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>BETH TFILOH</b>	
24D. LOCATION <b>BALTIMORE, MARYLAND</b>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1969</b>		25B. NAME OF REGISTRAR <b>[REDACTED]</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>	

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69 0504 BALTIMORE CITY HEALTH DEPARTMENT  
69 0504 CERTIFICATE OF DEATH

REG. NO. 69 0504

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Charles W. Seebach</b>		2. DATE AND HOUR OF DEATH <b>Jan. 12, 1969</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Q.O.C. 52-00</b>		C. CITY OR TOWN <b>Brooklyn</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>43 South Balto. General Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>Feb. 12, 1909</b>		9. AGE (In years last birthday) <b>59</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>Harry Seebach</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Eber</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Edna L. Seebach</b>	
ADDRESS <b>109 8th. Ave.</b>					
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Coronary heart disease</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Coronary heart disease</b>			
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>XXXXXX</del> attended the deceased from <b>1/9/69</b> to <b>1/12/69</b> and that (I) <del>XXXX</del> last saw the deceased alive on <b>1/11/69</b> and that in (my) <del>XXXX</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>XXXX</del> (did) <del>XXXX</del> view the body after death.					
23A. SIGNATURE <i>Samuel Rubin</i>		23B. DATE SIGNED <b>1/14/69</b>		23C. PHYSICIAN'S NAME (Type) <b>Samuel Rubin, M.D.</b>	
23D. ADDRESS <b>203 E. Patapsco Avenue Baltimore, Md. 21225</b>		23E. MED. DIRECTOR Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1 16 69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Cedar Hill</b>	
24D. LOCATION <b>Brooklyn, A. A. Co. Md.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1969</b>			
25A. NAME OF REGISTRAR <i>Robert S. Fagbema</i>		25B. FUNERAL DIRECTOR <b>Mc Gully</b>		25C. ADDRESS <b>130 E. Fort Ave</b>	

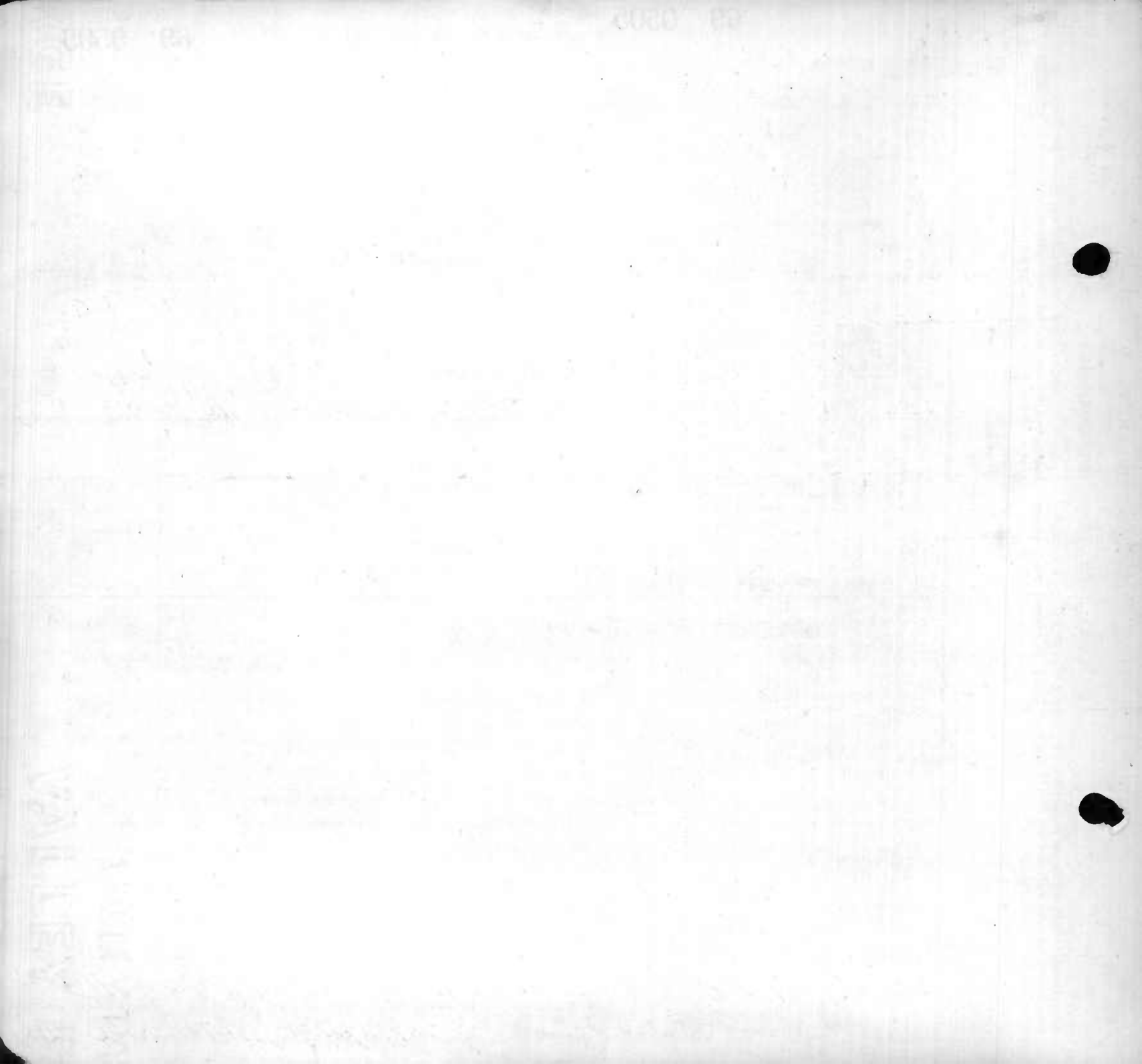


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BIRTH NO. 69 0505				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 0505			
1. NAME OF DECEASED (Type or Print) <b>WILLIAM GREENWOOD</b>				2. DATE AND HOUR OF DEATH <b>1-14-69, 12:40 P.M.</b>				M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Sinai Hospital of Baltimore</b> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>42 Belvedere Avenue at Greenspring, Baltimore, MD 2125.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Carroll Co.</b> C. CITY OR TOWN <b>Westminister</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				E. STREET AND NUMBER <b>10 Poole Road. ; 21157.</b>			
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 6, 1902</b>		9. AGE (In years lost birthday) <b>66 yrs.</b>		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>superintendent RUG MILL</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>WILMINGTON DEL.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>GEORGE R. GREENWOOD</b>				14. MOTHER'S MAIDEN NAME <b>ANNIE WEST</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES Nov. 26, 1918 to Aug 26, 1919</b>				16. SOCIAL SECURITY NO. <b>183-07-9376</b>		17. INFORMANT <b>MRS RALPH B. STEPHAN</b>				ADDRESS <b>320 STONER AVE. WESTMINSTER, MD.</b>	
18. <b>E 884 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Terminal Bronchopneumonia</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Fracture neck (R) femur</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Flexion Contractures of extremities.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12-20-68</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Multiple bed sores; epididymo-orchitis.</b>											
19A. DATE OF OPERATION <b>12-27-68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Fracture neck (R) femur</b>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Nursing Home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>House of Pines Nursing home</b>							
21D. TIME OF INJURY (APPROX.) <b>Dec. 20th. 1968 night</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Fell out of bed</b>							
22. I certify that (I) (this hospital) attended the deceased from <b>12-21-1968</b> to <b>1-14-1969</b> , that (I) (we) last saw the deceased alive on <b>1-14-1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>R. Palekar</b> M.D. DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>1-14-69.</b>			
23C. PHYSICIAN'S NAME (Type) <b>R. Palekar</b> M.D. DEGREE				23D. ADDRESS <b>Sinai Hospital of Baltimore</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/17/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>KRIDERS CEMETERY</b>				24D. LOCATION (City, town, or county) (State) <b>WESTMINSTER, MD.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fink</b>		25C. FUNERAL DIRECTOR <b>J. S. Myers Jr.</b>		ADDRESS <b>Westminister, Md.</b>					



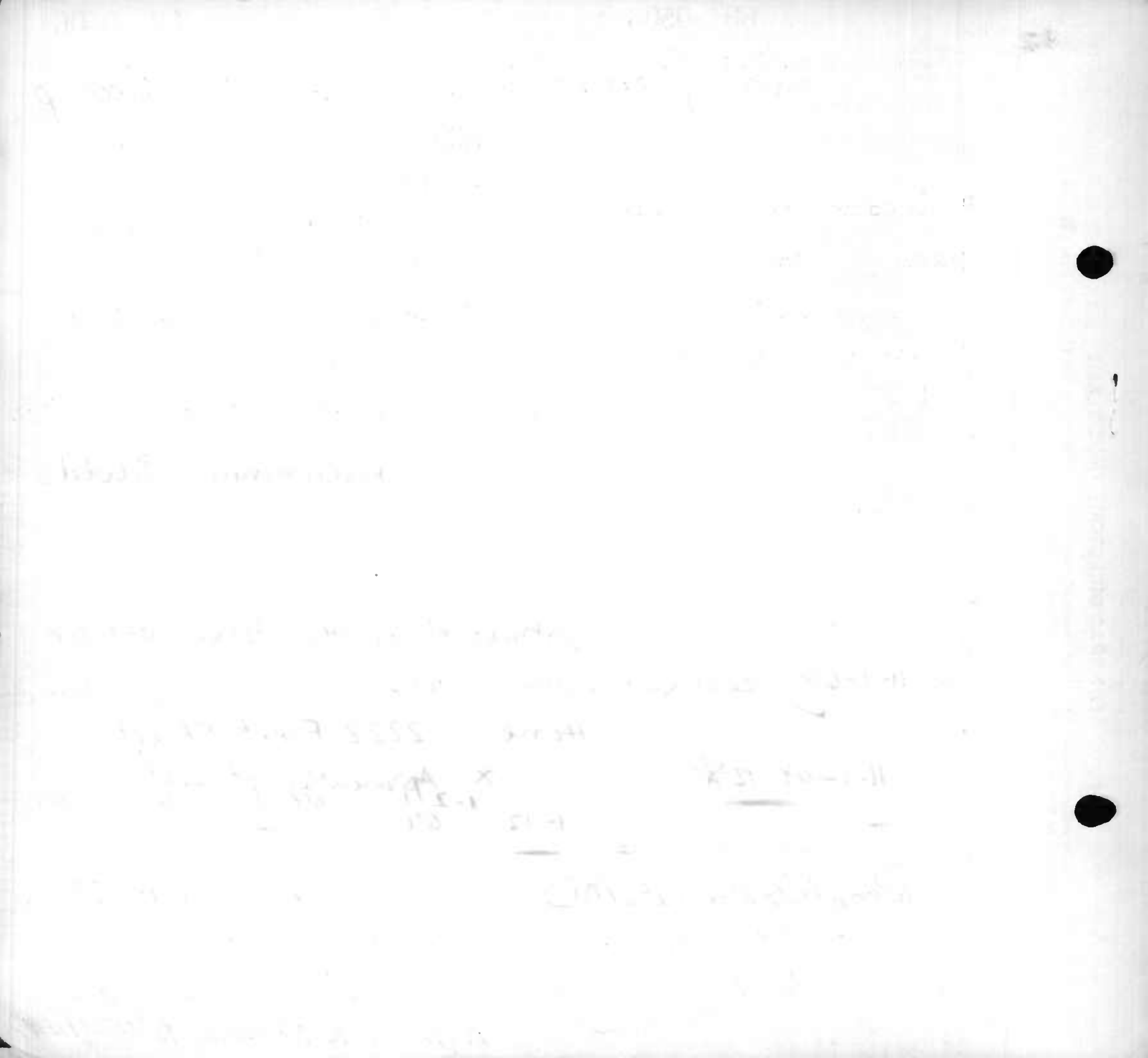


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Released by the Medical Examiner's Office on Approval by Dr. Kornblum

BALTIMORE CITY HEALTH DEPARTMENT				69 0506	
BIRTH NO.				REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>ANDREW J. STACHOWSKI</b> <b>Anthony Ustaszewski</b>				2. DATE AND HOUR OF DEATH <b>1-12-69 16:00 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 The Johns Hopkins Hospital</b>				C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <b>2222 Fleet St.</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/13/04</b>	9. AGE (In years last birthday) <b>64</b>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ASSEMBLYMAN</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>MARTIN'S</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>			13. FATHER'S NAME <b>Alexander Ustaszewski</b>		
14. MOTHER'S MAIDEN NAME <b>Mary Czarnecki</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>313-25-6600</b>			17. INFORMANT <b>MRS. MARIE USTASZEWSKI</b>		
ADDRESS <b>2222 FLEET ST.</b>			18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>II TRAUMATIC Intracerebral Hematoma</b>			11-1-68		
19A. DATE OF OPERATION <b>2-11-1-68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cerebral hematoma</b>		20A. AUTOPSY? (Yes or No) <b>yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	
21C. WHERE DID INJURY OCCUR? <b>2222 Fleet Street</b>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>11-1-68 12:01 A</b>		21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <b>Apparently pt fell</b>		22. I certify that (I) (the <del>hospital</del> ) attended the deceased from <b>1-2-69</b> to <b>1-12-69</b> and that (I) (we) last saw the deceased alive on <b>1-12-69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Ronald Michels M.D.</b>				23B. DATE SIGNED <b>1-13-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Ronald Michels, M.D.</b>				23D. ADDRESS <b>The Johns Hopkins Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1/16/69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>HOLY ROSARY CEMETERY</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE M.D.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1969</b>			
25B. NAME OF REGISTRAR <b>Robert E. Janney</b>		25C. FUNERAL DIRECTOR <b>RAYMOND L. KACZOROWSKI</b>			
ADDRESS <b>2525 FLEET ST.</b>					



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 0507

BIRTH NO.

## 1. NAME OF DECEASED

(Type or Print)

JOSHUA EPPS JK

## 2. DATE OF DEATH

Known ☒ Estimated ☐

Month

Day

Year

Hour

1

14

69

4:45 p.m.

## 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR IN INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Mercy Hospital D.O.A.

## 3. DATE PRONOUNCED DEAD

January 14, 1969

4:45 p.m.

## 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

9-09

## 6. SEX

Male

## 7. RACE

Colored

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

## C. CITY OR TOWN

Balto.

## D. INSIDE CITY LIMITS?

YES ☒NO ☐

## 9. DATE OF BIRTH

11-2-1908

## 10. AGE (In years last birthday)

60

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

## E. STREET AND NUMBER

1622 Harford Ave.

## 11. BIRTHPLACE (State or foreign country)

VIRGINIA

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

JOSHUA EPPS

## 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LABORER

## 14B. KIND OF BUSINESS OR INDUSTRY

LOCAL 194

## 15. MOTHER'S MAIDEN NAME

MARTHA CAMPBELL

## 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

N

## 17. SOCIAL SECURITY NO.

213-67-8108

## 18. INFORMANT

## ADDRESS

MARY EPPS 1622 HARFORD AVE.

15-4-1

## CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

## DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Carcinoma of the rectum  
DUE TO, OR AS A CONSEQUENCE OF:

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

## 20A. DATE OF OPERATION

## 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

## 21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

## 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

## 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

## 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

## 22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

## 22F. HOW DID INJURY OCCUR?

## 23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE  
EXAMINER'S NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/15/69

## 24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

## 24B. DATE

1-18-69

## 24C. NAME OF CEMETERY or CREMATORY

MT ARLINGTON

## 24D. LOCATION (City, town, or county)

BALTIMORE Md.

## 25A. DATE REC'D BY HEALTH DEPT.

JAN 17 1969

## 25B. NAME OF REGISTRAR

Robert E. Farber

## 25C. FUNERAL DIRECTOR

JOSEPH KNIGHT 1639 N. BROADWAY

0000

X

X

11-2-1968

WARRING

LABORER

IN

Local 1st MARTIN CAMPBELL

1000 W. 1st St. WARRING, WY.

WARRING

PRO

1-13-48 RT. 1000 W. 1st St. WARRING, WY.

WARRING, WY. 82201

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0508 BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 0508	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>MARYANNA MARY GORECKI</b>	
2. DATE AND HOUR OF DEATH <b>JANUARY 14 1969</b>				M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2225 FLEET STREET</b>				A. STATE <b>MARYLAND</b> B. COUNTY <b>1-04</b>	
C. CITY OR TOWN <b>BALTIMORE</b>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>2225 FLEET STREET</b>					
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-26-1889</b>	9. AGE (In years last birthday) <b>85 YRS</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>POLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>LAWRENCE SIWAK</b>		
14. MOTHER'S MAIDEN NAME <b>VICTORIA</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>MRS. EVELYN SQUIRE 603 S. BELNORD AVE</b>		
18. <b>794 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Senility</b>	
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>July 21 1958</b> to <b>Jan. 14 1969</b> , that (I) (we) last saw the deceased alive on <b>Dec. 29 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Sigmund R Nowak M.D.</b> Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>Jan. 15, 1969</b>	
23C. PHYSICIAN'S NAME (Type) <b>SIGMUND R. NOWAK MD</b>				23D. ADDRESS <b>408 S. PATTERSON PK AVE. 21231</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1/18/69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>HOLY ROSARY CEMETERY</b>	
24D. LOCATION (City, town, or county) <b>BALTIMORE MARYLAND</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Janina</b>		25C. FUNERAL DIRECTOR <b>RAYMOND L. KACZOROWSKI</b> ADDRESS <b>2525 FLEET ST.</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 0509				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 69 0509			
1. NAME OF DECEASED (Type or Print) <i>Margaret Badewitz</i>				2. DATE AND HOUR OF DEATH <i>1/15/69</i> <i>2 A.M.</i>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Ind</i> B. COUNTY <i>19-02</i>							
FULL NAME OF HOSPITAL OR INSTITUTION <i>00</i>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>1402 McHenry St.</i>							
5. SEX <i>F.</i>		6. RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1/8/1900</i>		9. AGE (In years lost birthday) <i>69</i>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Embroidering</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>Sign Bros. Co.</i>				11. BIRTHPLACE (State or foreign country) <i>Bach, Ind.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Pyman</i>				14. MOTHER'S MAIDEN NAME <i>Elyzabeth Larkin</i>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>✓</i>				16. SOCIAL SECURITY NO. <i>218-07-1318 D</i>				17. INFORMANT <i>Helen Sturm</i> ADDRESS <i>21218 Delverne Rd.</i>			
18. <i>4/10/91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Coronary Infarction</i>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerosis</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) _____ (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION <i>0</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Nov 15</i> 19 <i>68</i> to <i>Nov 15</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Nov 15</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.											
23A. SIGNATURE <i>H. H. Baylus</i>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <i>15 Jan 1969</i>			
23C. PHYSICIAN'S NAME (Type) <i>H. H. BAYLUS</i>				23D. ADDRESS <i>1600 Wilkens Ave</i>							
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>1/20/69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore National Cem</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 17 1969</i>				25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>				25C. FUNERAL DIRECTOR <i>John J. Gowanston Inc.</i> ADDRESS <i>23, Md.</i>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT

## 69 0510 CERTIFICATE OF DEATH

REG. NO.

69 0510

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

RAYMOND BANKS

2. DATE AND HOUR OF DEATH

1-13-69 5:40 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNIVERSITY HOSPITAL BALTIMORE  
MARYLAND 21201

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

MARYLAND.

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

1527 N. Gilmore St.

5. SEX

MALE

6. RACE

COLOR

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

7-3-34

9. AGE (In years last birthday)

34

10. Under 1 Yr. Months Days

11. Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

SOLIMON BANKS

14. MOTHER'S MAIDEN NAME

BENNIE ROBINSON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

226-38-2783

17. INFORMANT

ADDRESS

Ruth Ann Banks 1527 N. Gilmore St.

18. 430.91

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

PULMONARY EMBOLI

(B)

DUE TO, OR AS A CONSEQUENCE OF:

RECURRENCE SUBARACHNOID HEMORRAGE

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)

☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-10-68 19 to 1-13 1969 that (I) (we) last saw the deceased alive on 1-13 1969 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

A. Srikumpol

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1-13-69

23C. PHYSICIAN'S NAME (Type)

A. SRIKUMPOL, M.D.

23D. ADDRESS

UNIVERSITY HOSPITAL OF MARYLAND

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

1-17-69

Mt Auburn Cem.

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

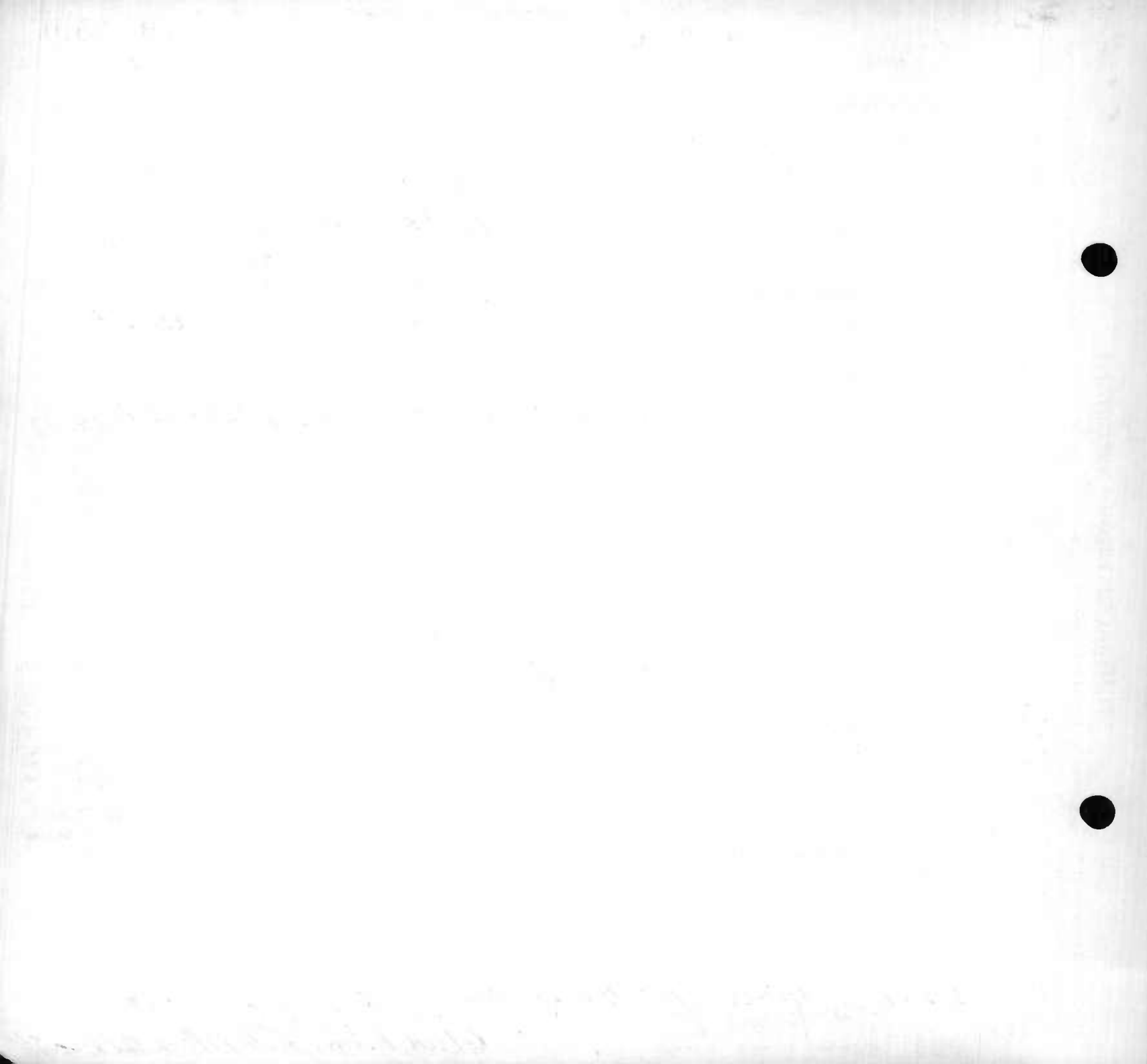
25C. FUNERAL DIRECTOR

ADDRESS

JAN 17 1969

Robert E. Taylor

Kellogg Funeral Home 1348 N. Calhoun St.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0511

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 69 0511

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*Evelyn Barr*

2. DATE AND HOUR OF DEATH

*1-15-69 9<sup>15</sup> P.M.*

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

*33 Johns Hopkins Hospital  
601 N. Broadway Balto 21205*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
B. COUNTY

*MARYLAND*

C. CITY OR TOWN

*BALTIMORE*

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

*2015 DIVISION ST 21217*

5. SEX

*F*

6. RACE

*N*

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

*12-8-13*

9. AGE (In years last birthday)

*55*

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*TEACHER*

10B. KIND OF BUSINESS OR INDUSTRY

*BALTO., PUBLIC*

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

*U.S.A.*

13. FATHER'S NAME

*EDWIN WESCOTT*

14. MOTHER'S MAIDEN NAME

*MARY JOHNSON*

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

*212-36-5740*

17. INFORMANT

ADDRESS

*Kenna Fleming 2015 Division St.*

18. *154.1 I*

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

*Respiratory arrest*

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

*5 minutes*

(B) *Intestinal + ureteral obstruction 3 weeks*  
DUE TO, OR AS A CONSEQUENCE OF:

(C) *Metastatic disease of pelvis 13 mos.*

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

*Early renal failure & pyelonephritis*

*2 weeks*

19A. DATE OF OPERATION

*11/68 and 10/68*

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

*Intestinal obstruction*

20A. AUTOPSY? (Yes or No)

*No*

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (A) (this hospital) attended the deceased from *12-23* 19 *68* to *1-15* 19 *69* that (B) (we) last saw the deceased alive on *1-15* 19 *69* and that (C) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (D) (We) (did) (to view) view the body after death.

23A. SIGNATURE

*Paul Tecklenberg, M.D.*

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

*1-15-69*

23C. PHYSICIAN'S NAME (Type)

*PAUL L Tecklenberg M.D.*

23D. ADDRESS

*Box #200 Johns Hopkins Hospital  
601 N. Broadway Balto. 21205 MD*

24A. BURIAL CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*1-20-69*

24C. NAME of CEMETERY or CREMATORY

*Arbutus Mem. Pk.*

24D. LOCATION

*Arbutus Mem. Pk.*

25A. DATE REC'D BY HEALTH DEPT.

*JAN 17 1969*

25B. NAME OF REGISTRAR

*Robert E. Taylor*

25C. FUNERAL DIRECTOR

*Nelson Funeral Home*

ADDRESS

*1348 N. Calhoun St.*

171

MP

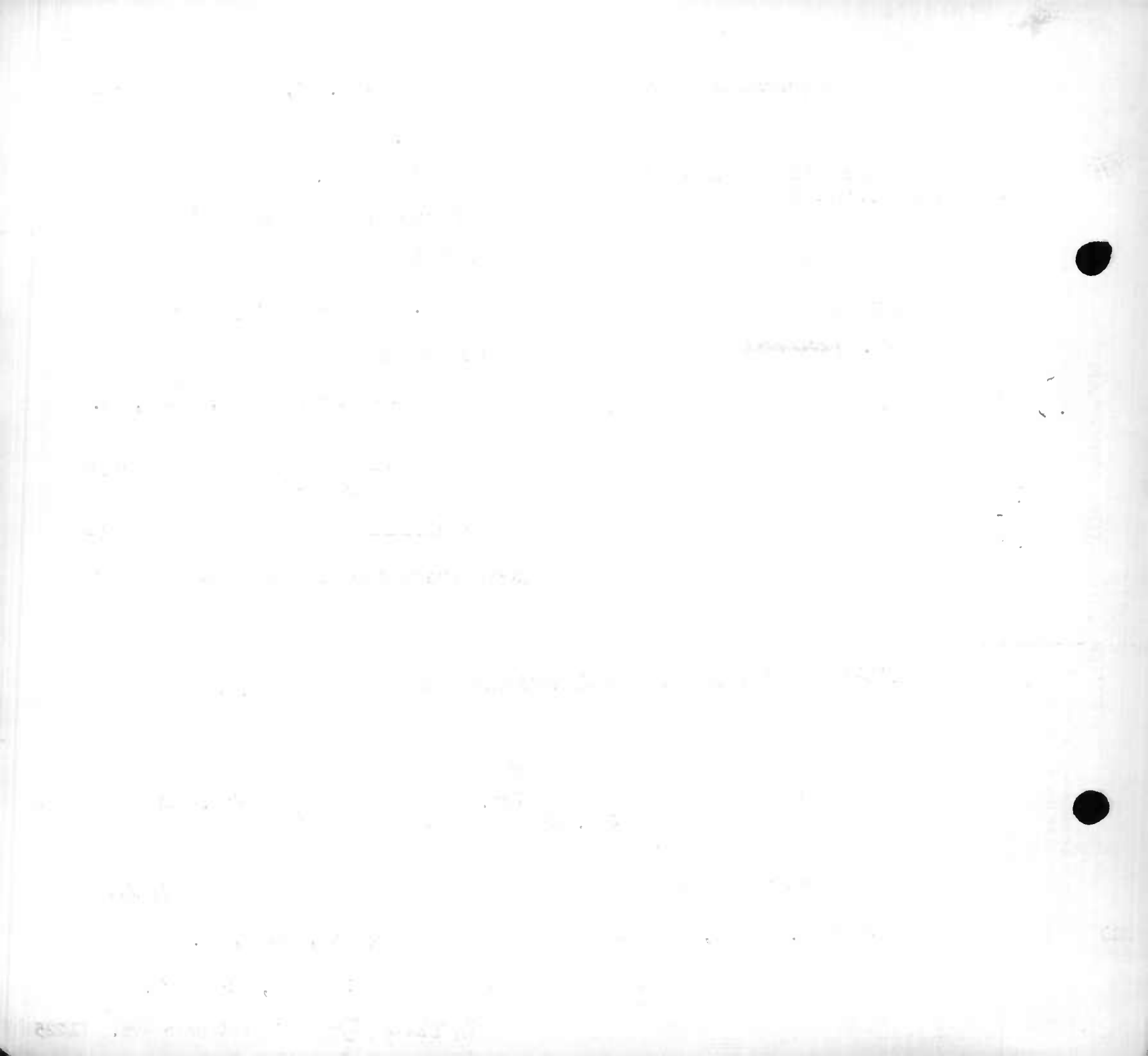
171

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 00512		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 00512	
1. NAME OF DECEASED (Type or Print) <b>Margarette Anne MacCorkle Du Mond</b>			2. DATE AND HOUR OF DEATH <b>Jan. 14, 1969 2: 15 A M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>US Public Health Service Hospital 3100 Wyman Parkway</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>A.A.C. 52-00</b>		
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>11/25/10</b> 9. AGE (In years last birthday) <b>58</b>	
11. BIRTHPLACE (State or foreign country) <b>Pa. (Philadelphia)</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Wm. MacCorkle MacCorkle</b>			14. MOTHER'S MAIDEN NAME <b>Louise Helme</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT ADDRESS <b>Records- US PHS Hospital, Balto, Md.</b>	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonitis due to aspiration</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Peritonitis</b>				<b>Days</b>	
(c) <b>Ruptured diverticulum sigmoid colon</b>				<b>Days</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>3 1/9/69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ruptured sigmoid diverticulum</b>		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>yes</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan. 7 1969</b> to <b>Jan. 14 1969</b> that (I) (we) last saw the deceased alive on <b>Jan. 14 1969</b> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>James M. Weaver</b>				23B. DATE SIGNED <b>1/14/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>James M. Weaver, Medical Director</b>		23D. ADDRESS <b>US PHS Hospital, Balto, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/17/69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>New Prospect Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Pine Bush, New York.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 16 1969</b>			
25B. NAME OF REGISTRAR <b>Robert Jackson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>McCully F.H. 237 Patapsco Ave. 21225</b>			

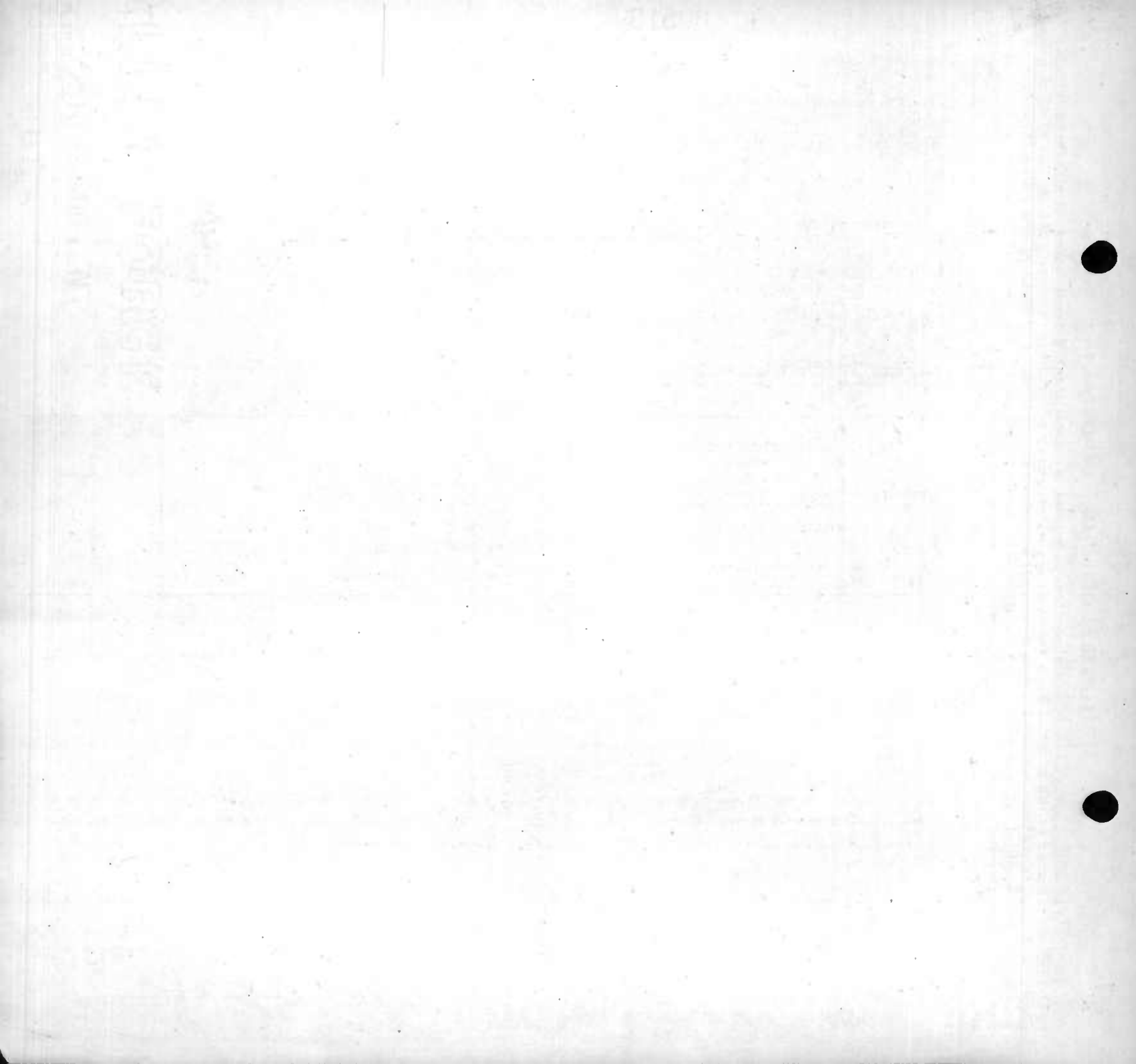




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

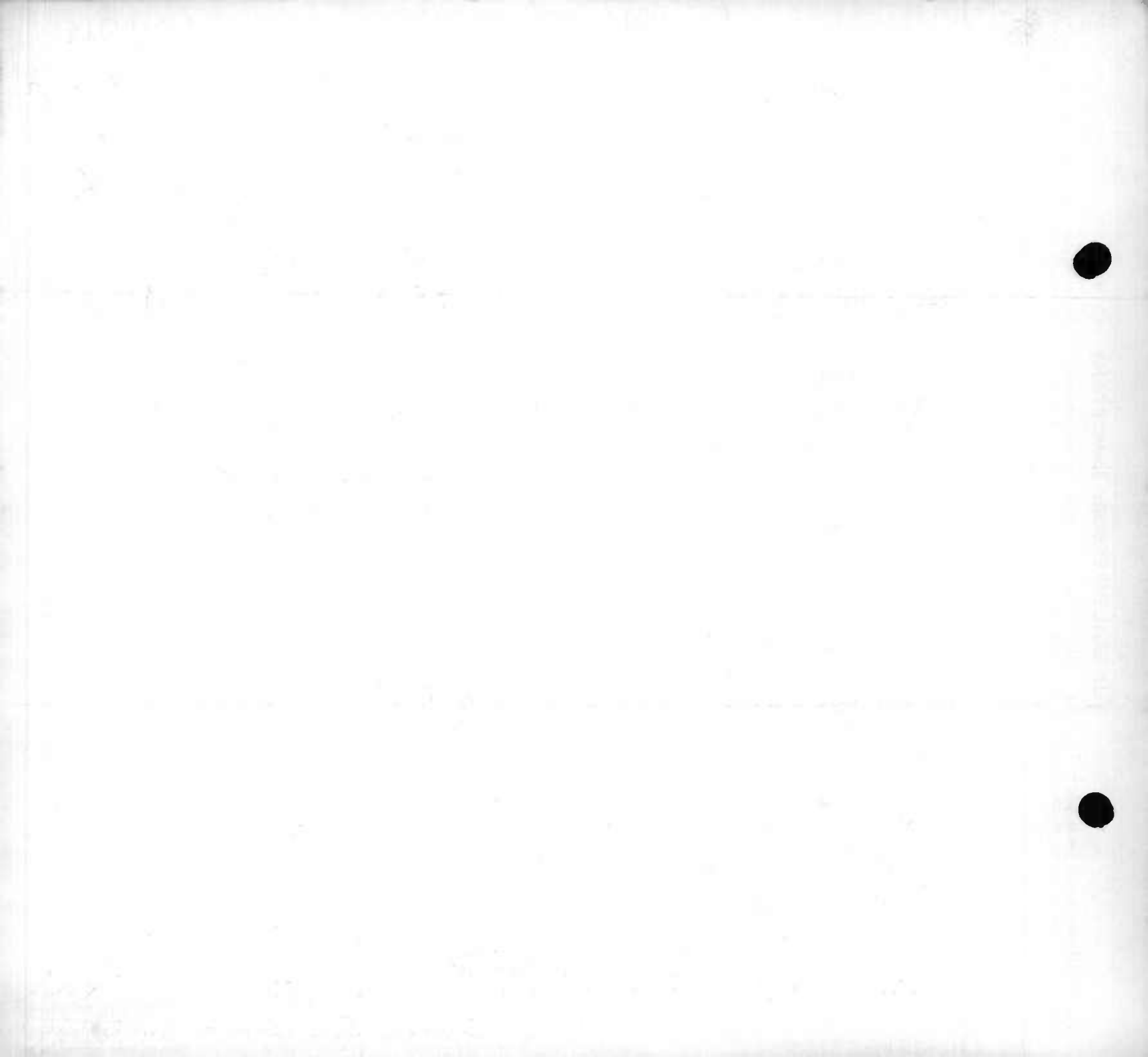
BIRTH NO.				BIRTH NO.			
1. NAME OF DECEASED (Type or Print) <b>ERNEST SCHLEUNING</b>				2. DATE AND HOUR OF DEATH <b>1/13/69 7:00 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>27-57</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>BELAIR HOUSE IN PINES</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
ADDRESS OR LOCATION <b>5837 BELAIR RD.</b>				E. STREET AND NUMBER <b>6602 MARIETTA AVE</b>			
5. SEX <b>M</b>	6. RACE <b>CAV</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT 7 1900</b>	9. AGE (In years last birthday) <b>68</b>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Expediter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Martin - Marietta</b>		11. BIRTHPLACE (State or foreign country) <b>Newark N.J.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>075-10-3002</b>		17. INFORMANT <b>Mrs Ethel Schleuning</b>				ADDRESS <b>4602 Marietta Ave</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral thrombosis due to cerebral arteriosclerosis</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 yrs</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <b>Heart Disease - Enlarged Heart - Congestive Failure - Stasis - Premature</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Enlarged Heart - Congestive Failure - Stasis - Premature</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 13 July 1960</b> to <b>Jan 13 1969</b> , that (I) (we) lost saw the deceased alive on <b>Jan 13 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Donald W. Mintzer MD</b>				23B. DATE SIGNED <b>Jan 13 1969</b>		23C. PHYSICIAN'S NAME (Type) <b>DONALD W. MINTZER MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>1/16/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Parkwood Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Belts Md.</b>				24E. ADDRESS <b>3009 EVER GREEN AVE BALTO MD</b>		24F. DATE REC'D BY HEALTH DEPT. <b>JAN 16 1969</b>	
25A. NAME OF REGISTRAR <b>Robert E. Farber</b>				25B. FUNERAL DIRECTOR <b>Adrian Per</b>		25C. ADDRESS <b>RR 59401</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

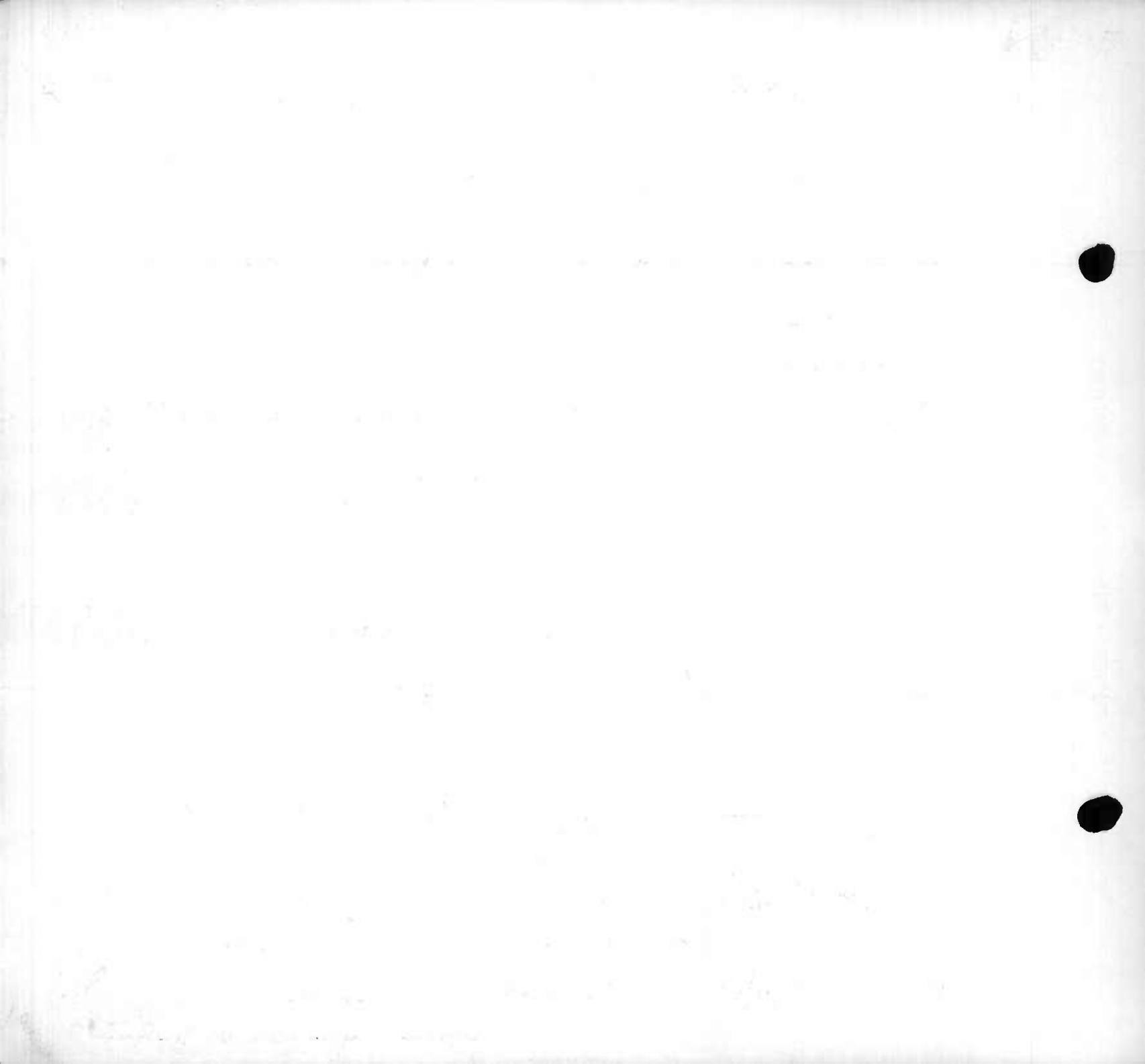
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>60 00514</u>
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>NANCY Schloss</u>		2. DATE AND HOUR OF DEATH <u>13 JAN 1969 8:30 AM</u>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institutional: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u> Sinai Hospital of Baltimore</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <u>Female</u>		6. RACE <u>Cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>Nov 2, 1922</u> 9. AGE (In years last birthday) <u>46</u>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		11. BIRTHPLACE (State or foreign country) <u>Phila, Pa</u>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>180-16-9936</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
17. INFORMANT <u>M. Earl Schloss</u>		ADDRESS <u>Same</u>		
18. <u>174 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CANCER of Breast</u> <u>= Metastasis</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
MEDICAL CERTIFICATION				
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <del>the</del> (this hospital) attended the deceased from <u>31 Dec</u> 19 <u>69</u> to <u>13 JAN</u> 19 <u>69</u> that <del>the</del> (we) last saw the deceased alive on <u>13 JAN</u> 19 <u>69</u> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>the</del> (We) (did) <del>not</del> view the body after death.				
23A. SIGNATURE <u>Morris Ostroff, MD</u>		23B. DATE SIGNED <u>13 JAN 1969</u>		23C. PHYSICIAN'S NAME (Type) <u>Morris Ostroff, MD</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>cremation</u>		24B. DATE <u>1/16/1969</u>		24C. NAME OF CEMETERY or CREMATORY <u>London Park</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 16 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Tarkenton</u>		25C. FUNERAL DIRECTOR <u>Sylvan S. Lewis &amp; Son, Inc</u>
				ADDRESS <u>9610 Reisterstown Rd</u>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
6000515		6000515		6000515	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
HYMAN, Belle		1/15/69		5 <sup>25</sup> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Md		B. COUNTY 17-17	
425 Sinai Hosp. of Balt		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER LEVINDALE ENPIRARY - previous address UNKNOWN			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-18-94	9. AGE (in years last birthday) 74	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Russia	
13. FATHER'S NAME Aaron		14. MOTHER'S MAIDEN NAME Sumia		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Theodore Frank 3617 Glenvale Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.4 I ASCVD - Senes, n.k. cardiac arrhythmia (A.V. Block)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 years 7 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ① Rheumatoid Arthritis ② Ch. Lung Disease		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/9 1969 to 1/15 1969 that (I) (we) last saw the deceased alive on 1/15 1969 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Paul D. Krieger MD		23B. DATE SIGNED 1-15-69		23C. PHYSICIAN'S NAME (Type) PAUL D. KRIEGER MD	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1/16/69		24C. NAME OF CEMETERY or CREMATORY Beth Tefeloh	
25A. DATE REC'D BY HEALTH DEPT. JAN 16 1969		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Sylvan S. Lewis & Son, INC 9610 Reisterstown Rd	





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

67 00516

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CHARLES Hale FOLEY, Sr.</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>31 Baltimore City Hospitals</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 13, 1969 9:35 A.M.</b>	
6. SEX <b>male</b>		7. RACE <b>white</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
9. DATE OF BIRTH <b>Oct. 1, 1927</b>		10. AGE (In years last birthday) <b>41</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Heaters, W. Va.</b>		12. CITIZEN OF <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner-Operator</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Auto Repair Shop</b>	
15. MOTHER'S MAIDEN NAME <b>Louie Conrad</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>	
17. SOCIAL SECURITY NO. <b>215 28 8122</b>		18. INFORMANT <b>Phyllis Foley</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Gunshot Wound of Chest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>1504 Eastern Avenue</b>		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>1/13/69 8:30 A.M.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>subj. shot self in chest</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) DATE SIGNED <b>1/14/69</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/16/69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 16 1969</b>		25B. NAME OF REGISTRAR <b>R. E. Farkas</b>	
25C. FUNERAL DIRECTOR <b>Bruzdzinski Funeral Home</b>		25D. ADDRESS <b>1407 Eastern Ave.</b>	

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Oct. 1, 1967

John Foley

USA

Master, N. Y.

Leads County

Auto repair shop

Owner-Operator

Conn

Flyline Foley

213 28 613

Yes

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MAILED 10001

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## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

6:00517

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 6:00517

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>STEINER, ARTHUR CHARLES</b>		2. DATE AND HOUR OF DEATH <b>JANUARY 12, 1969 11:05 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>21122</b>		5. SEX <b>MALE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. AGNES HOSPITAL WILKENS &amp; CATON AVES. BALTIMORE, MD. 21229</b>		C. CITY OR TOWN <b>PASADENA,</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>RT #10 BOX 247 GARLAND RD.-LAKE</b>		6. DATE OF BIRTH <b>05-29-99</b>		7. AGE (In years last birthday) <b>68</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED-CHAUFFEUR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>CONWAY FURNITURE COMPANY</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>CHARLES STEINER</b>		14. MOTHER'S MAIDEN NAME <b>IDA HOYLE</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215052777</b>		17. INFORMANT <b>BALTIMORE, MD. 21229 ST. AGNES RECORDS, WILKENS &amp; CATON AVES.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>410.9+199.0</b> <b>Acute Pulmonary Edema</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute Myocardial Infarction</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Generalized Calcinos malaris primary diabetes</b>		19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>DECEMBER 27 1968</b> to <b>JANUARY 12 1969</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>JANUARY 12 1969</b> and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE <b>Alejandro Mejia MD</b>		23B. DATE SIGNED <b>1-13-69</b>		23C. PHYSICIAN'S NAME (Type) <b>ALEJANDRO MEJIA MD</b>	
23D. ADDRESS <b>St Agnes Hospital - Wilkens &amp; Caton Aves.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/16/69</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>		24D. LOCATION <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 16 1969</b>	
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Singleton Funeral Home, Glen Burnie, Md.</b>		25D. ADDRESS	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

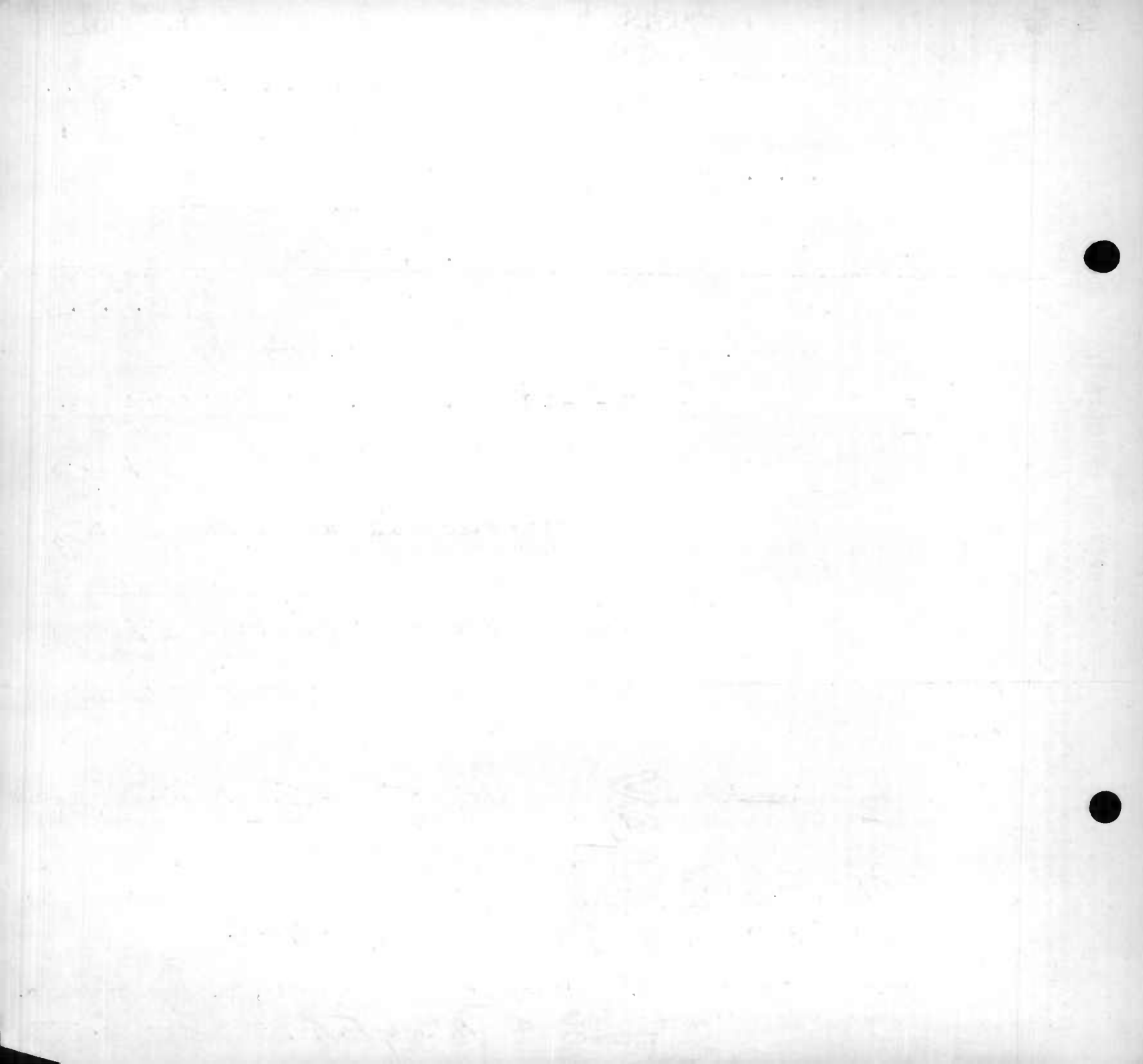
6 00518

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

6 00518

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Golda Drury Owens</b>		2. DATE AND HOUR OF DEATH <b>January 13, 1969</b>   <b>9:30 A.M.</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>25-34</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>43/99</b> <b>D. O. A. South Baltimore General Hospital</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>304 Washburn Avenue</b>		<b>21225</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 24, 1890</b>	9. AGE (In years last birthday) <b>78</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practical Nurse</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Nelson W. Owens</b>		14. MOTHER'S MAIDEN NAME <b>Ida L. Drury</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-32-1141</b>		17. INFORMANT <b>Mrs. Mazie S. Hopkins</b> ADDRESS <b>6007 Cedonia Ave.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>4/23/1250.9</b> <b>congestive failure.</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic heart disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Dislike her well ites</b>		(C) <b>10 yr.</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>10/15</b> 19 <b>58</b> to <b>1/13</b> 19 <b>69</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>1/4</b> 19 <b>69</b> and that in (my) ( <del>my</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>M. Freeman</b>		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <b>M. Freeman</b>		23D. ADDRESS <b>11 W 24th St</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/16/69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>St. Anne's Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Annapolis, Md. Anne Arundel Co.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 16 1969</b>		25B. NAME OF REGISTRAR <b>McCallie Folk</b>	
25C. FUNERAL DIRECTOR ADDRESS <b>237 Patapsco Ave. 21225</b>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 67 00519	
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>CHARLES KRESPACH</b>		2. DATE AND HOUR OF DEATH <b>1/11/69 4 10 P M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Balto Co.</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>45 Good Samaritan Hospital</b> <b>Lock Raven &amp; Belvedere</b>			C. CITY OR TOWN <b>Balto</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>2911 ANDORRA COURT</b>		
5. SEX <b>M</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>04-03-88</b>	9. AGE (In years last birthday) <b>80</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>CHARLES W. KRESPACH</b>			14. MOTHER'S MAIDEN NAME <b>CAROLINE ROCKER</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>712-01-1099</b>		17. INFORMANT <b>1538 EMBREY PLACE</b> <b>MRS LOUISE BERGER CROFTON MD</b>	
18. <b>250.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>myocardial infarct</b> <b>A.S.C.V.D. with C.V.A.</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Hypertension</b> (B) <b>Diabetes Mellitus.</b> DUE TO, OR AS A CONSEQUENCE OF: <b>C.O.P.D</b> (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 months.</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>B.P.H. bilat. Hydrocele.</b> <b>bilateral cataracts.</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/30</b> 19 <b>68</b> to <b>1/11</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>1/11/</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>Georges Birenbaum M.D.</b> DEGREE				23B. DATE SIGNED <b>1/11/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>GEORGES BIRENBAUM M.D.</b> DEGREE				23D. ADDRESS <b>1807 Woodbourne Ave</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1/14/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>MORELAND PARK</b>	
24D. LOCATION (City, town, or county) <b>PARKVILLE MD</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 16 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>ULLRICH FUNERAL HOME-4210 BELAIR</b>	







FUNERAL DIRECTOR: IMPORTANT

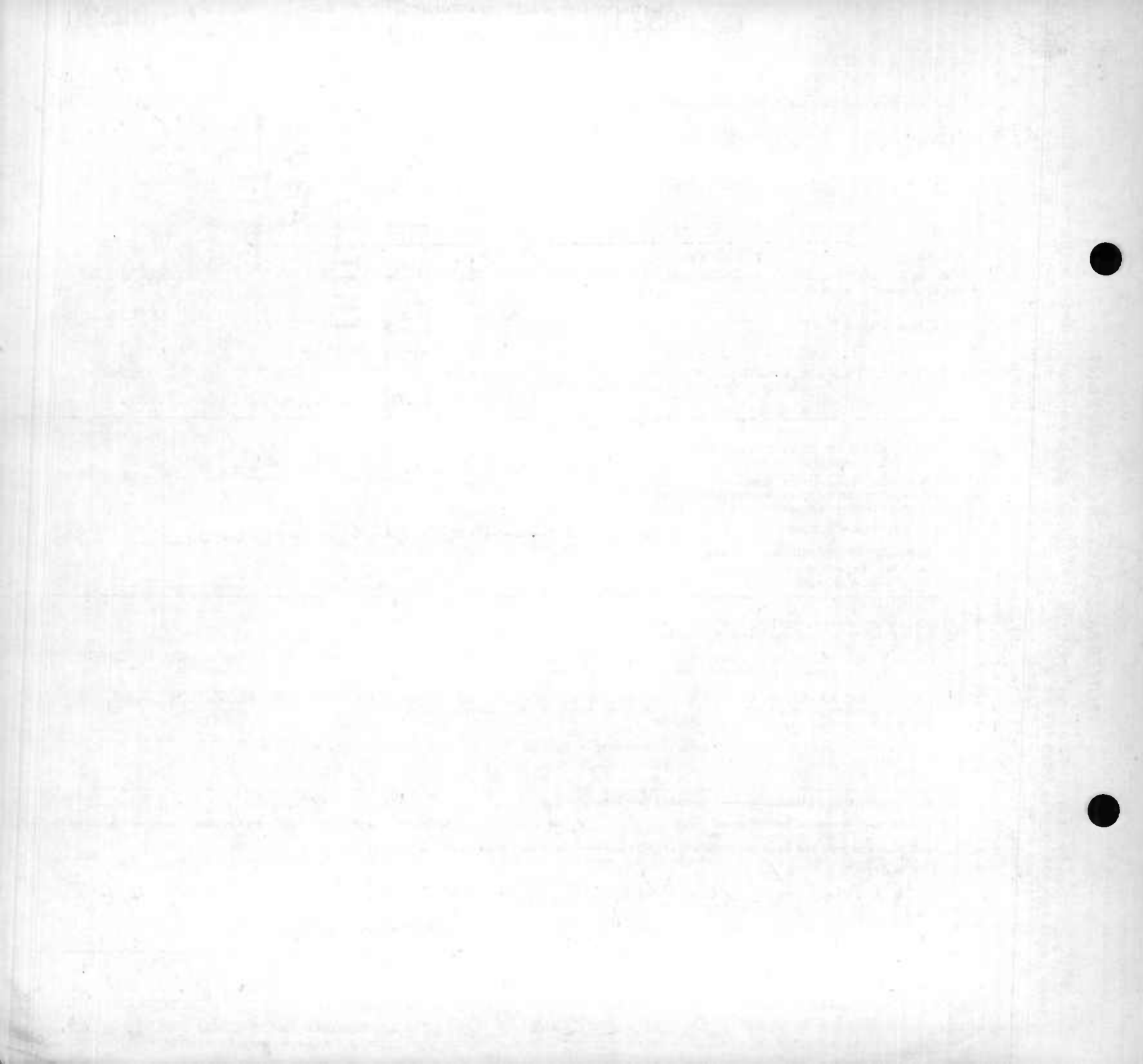
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67-00520

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 67-00520

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>KATE KEIL</b>		2. DATE AND HOUR OF DEATH <b>January 12, 1969</b> <b>7</b> <b>P</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> 8. COUNTY <b>26-42</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>00 4237 Seidel Ave.</b>		E. STREET AND NUMBER <b>4237 Seidel Ave.</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 31, 1876</b>	9. AGE (In years last birthday) <b>92</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John T. Keil</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Miller</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mrs. Hilda Bitzel, 4237 Seidel Ave.</b>	
18. <b>440.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Congestive heart failure</b> (B) <b>Generalized Arteriosclerosis</b> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>8/10</b> <b>1949</b> to <b>1/12</b> <b>1969</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>1/6</b> <b>1969</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>We</del> ) ( <del>did</del> ) (did not) view the body after death.					
23A. SIGNATURE <b>Thomas L. Worsely</b>		23B. DATE SIGNED <b>1/14/69</b>		23C. PHYSICIAN'S NAME (Type) <b>Thomas L. Worsely, M.D.</b>	
23D. ADDRESS <b>6505 York Road,</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/15/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION <b>Baltimore, Md.</b>					
25A. DATE RECEIVED BY HEALTH DEPT. <b>JAN 16 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Tishman</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Ullrich Funeral Home 4210 Belair Road.</b>	



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D-400

6700521 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

6700521

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>THOMAS J. DOYLE</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>1 12 69 6:10 p.m.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>City Hospital D.O.A.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 12, 1969 6:10 p.m.</b>	
6. SEX <b>Male</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balto.</b> C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
7. RACE <b>White</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>Jan. 4, 1897</b>		10. AGE (In years lost birthday) <b>72</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Doyle</b>		14. MOTHER'S MAIDEN NAME <b>Mary McNamara</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chipper</b>		16. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No Yes WW I</b>		18. SOCIAL SECURITY NO. <b>213-07-4534</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>412.4 I</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>II</b>		20. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (A) _____ (B) _____ (C) _____	
21. DATE OF OPERATION <b>0</b>		22. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>No</b>	
23. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		24. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?</b>	
25. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>22E. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		26. HOW DID INJURY OCCUR?	
27. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Edward F. Wilson</b> M.D. EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b> DATE SIGNED <b>1/13/69</b>			
28. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		29. DATE <b>1/16/69</b>	
30. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		31. LOCATION (City, town, or county) (State) <b>Overlea, Md.</b>	
32. DATE REC'D BY HEALTH DEPT. <b>JAN 16 1969</b>		33. NAME OF REGISTRAR <b>R. E. S. Taylor, M.D.</b>	
34. FUNERAL DIRECTOR <b>Ulrich Funeral Home Dundalk, Md.</b>		35. ADDRESS	

156100-3

RECEIVED TELETYPE UNIT

WATLEY BODROE

24/0000000000

X

2/11/72

100000000000

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 00522

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

HOMER HARTOBY GROSS

2. DATE OF DEATH

Known ☒Estimated ☐

Month

Day

Year

Hour

1

7

69

7:06 p

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Provident Hospital

3. DATE PRONOUNCED DEAD

January 7, 1969

7:06 p

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

14-03

6. SEX

Male

7. RACE

Colored

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

Mar. 11/1930

10. AGE (In years last birthday)

38 3/8

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1815 Little Walsh

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

William Gross

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Construction

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Helena Thornton

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes 12-45-41/46

17. SOCIAL SECURITY NO.

18. INFORMANT

Sadie Gross - 18 Jackson Lick Apt 4

ADDRESS

19.

571.8

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Fatty liver

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME (Month) (Day) (Year) (Hour) (Approx.) OF INJURY

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/8/69

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1/9/69

24C. NAME OF CEMETERY or CREMATORY

Balto Nat. Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore Md

25A. DATE REC'D BY HEALTH DEPT

JAN 16 1969

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

V. Brooks Ruggold 14637 Carver St

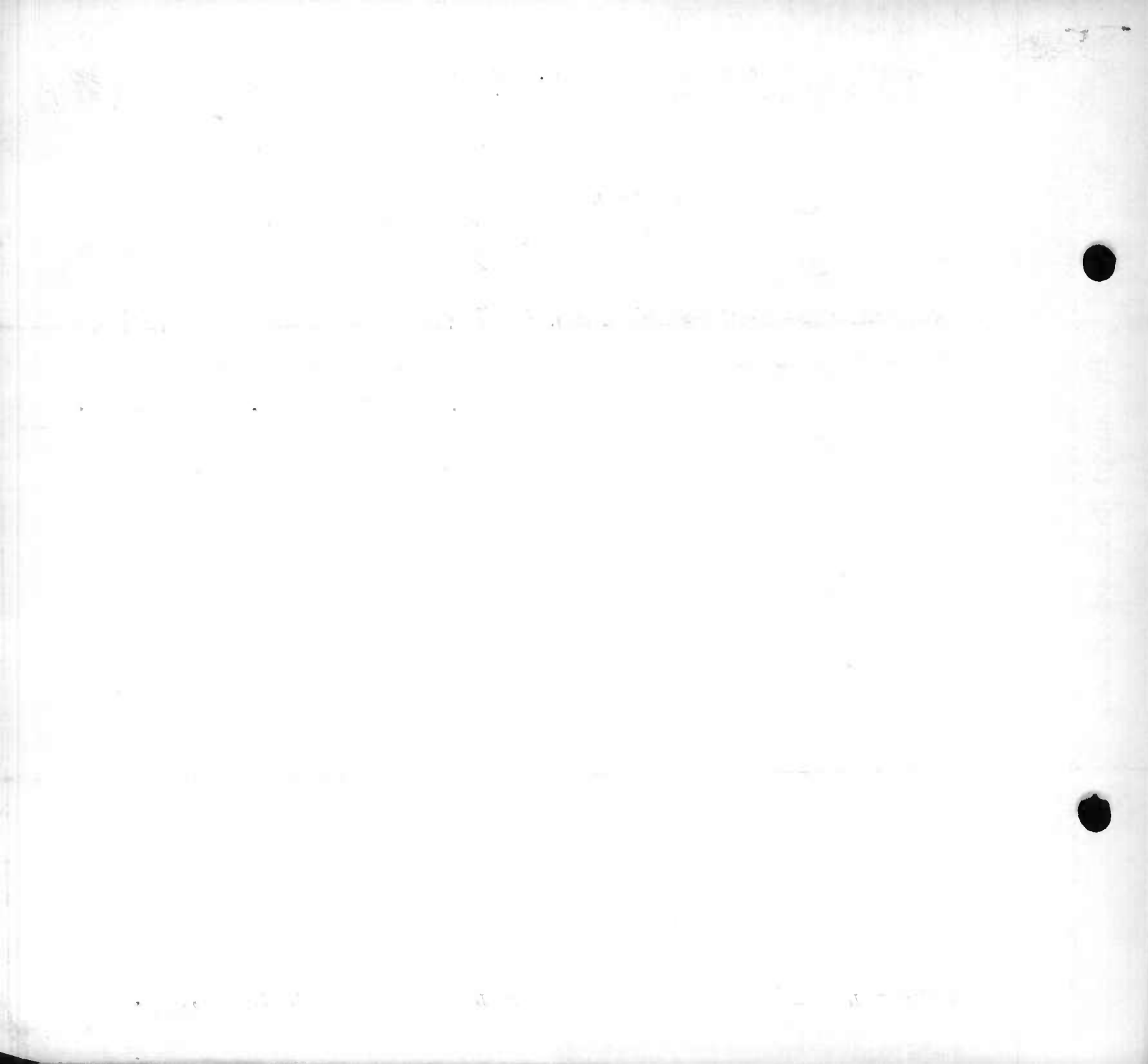
ADDRESS

Received 11/11/11 Baltimore Md  
The Bank of America

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JOSEPHINE MORRIS</b>		2. DATE AND HOUR OF DEATH <b>11/12/69 930 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>12-02</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>37 MERCY HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-23-90</b>	9. AGE (in years, last birthday) <b>78</b>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TEACHER (RETIRED)</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>PUBLIC SCHOOL</b>		11. BIRTHPLACE (State or foreign country) <b>SUSSEX (MARYLAND)</b>	
13. FATHER'S NAME <b>EUGENE MORRIS</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET MALONEY</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>EDW. MORRIS 813 N. CALVERT ST.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>412.31-199.1</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>A.S.H.D. - Ca</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If not, medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. J. J. J.</b>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>J. J. J. J.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1/15/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>NEW CATHEDRAL</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 16 1969</b>		25B. NAME OF REGISTRAR <b>R. J. J. J.</b>		25C. FUNERAL DIRECTOR <b>H. W. J. J.</b>	
25D. ADDRESS <b>Mercy Staff</b>		25E. ADDRESS <b>805 N. Calvert St.</b>			





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69 00524 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 00524

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JAMES EDWIN BARRY</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>44 Union Memorial Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 5, 1969 3:05 P.M.</b>	
6. SEX <b>male</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE <b>white</b>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>6/2/1924</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years lost birthday) <b>44</b>		E. STREET AND NUMBER <b>19 W. 29th Street</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>City of Balto.</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Unemployed</b>	
15. MOTHER'S MAIDEN NAME <b>Vera K. Kennard</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <b>NO NO</b>	
17. SOCIAL SECURITY NO. <b>219.18.6441</b>		18. INFORMANT ADDRESS <b>David Turnbull 1906 Rollingwood Rd.</b>	
19. <b>E8871X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Bilateral Pneumonia Complicating Cerebral Injury</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Antecedent Causes</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>vacant lot</b>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>found - 119 W. 29th St. (vacant lot)</b>		22D. TIME OF INJURY (APPROX.) <b>12/31/68 - 1/1/69</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subj. believed to have fallen following consumption of alcohol</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1/6/69</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/16/69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn</b>		24D. LOCATION (City, town, or county) (State) <b>Woodlawn Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 16 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>	
25C. FUNERAL DIRECTOR <b>J. I. Stansbury</b>		ADDRESS <b>6411 Windsor Mill Rd.</b>	

WALLINGTON

25% APRIL 1969

*James B. [Signature]*

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 00525
69 00525 CERTIFICATE OF DEATH				
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Nicholas GAUDINO</i>		2. DATE AND HOUR OF DEATH <i>JAN-12-69 9:00 A M.</i>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEATH (If not in hospital or institution, give street address or location) <i>1-20-69</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>6-02</i>		
		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <i>Male</i> 6. RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7-12-04</i> 9. AGE (In years last birthday) <i>64</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Steel</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Steel</i>		11. BIRTHPLACE (State of foreign country) <i>PENNA.</i>
13. FATHER'S NAME <i>Thomas GAUDINO Gaudino</i>		14. MOTHER'S MAIDEN NAME <i>JULIA QUATA</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Gaudino</i> ADDRESS <i>MARGARET GAUDINO 230 N. KENWOOD AVE.</i>
18. <i>250.91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>CVA</i> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Hypertension + GASVD</i> DUE TO OR AS A CONSEQUENCE OF:		<i>5 yrs</i>
		(C) <i>Diabetes Mellitus</i>		<i>5 yrs</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 7</i> 19 <i>69</i> to <i>Jan 12</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>Jan 12</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>H. Verdain Barnes, MD</i>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <i>H. VERDAIN BARNES, MD</i> DEGREE
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>1-16-69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Moreland Mem. Cem.</i>
24D. LOCATION (City, town, or county) <i>BALTO. MD.</i>		24E. FUNERAL DIRECTOR <i>B. DABROWSKI</i> ADDRESS <i>2814 E. BALTO. ST.</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 26 1969</i>		25B. NAME OF REGISTRAR <i>R. E. Jenkins</i>		25C. FUNERAL DIRECTOR <i>B. DABROWSKI</i> ADDRESS <i>2814 E. BALTO. ST.</i>

CONFIDENTIAL

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1/20/69 - 1/20/69  
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1/20/69 - 1/20/69

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

6 00526

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOYCE SMITH

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

January 8, 1969

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Church Home &amp; Hospital

(DOA)

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

January 8, 1969

5:38 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

2-01

6. SEX

7. RACE

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

Female

White

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Baltimore

Yes ☒No ☐

9. DATE OF BIRTH

10. AGE (In years  
last birthday)If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

Oct. 7, 1924

42

E. STREET AND NUMBER

2027 East Lombard Street

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF

WHAT COUNTRY?

13. FATHER'S NAME

London, England

U.S.A.

Henry Grouchet

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Housewife

Maude A. White

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

No

M. Kiwakowski 5213 Saybrook Rd.

19. 486X I

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Bilateral pneumonia  
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)  
(Partial)  
Yes22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

January 9, 1969

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Burial

1-14-69

Balto. Natl Cemetery

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JAN 16 1969

Robert E. Taylor, M.D.

B. Dabrowski 2818 E. Baltimore St.



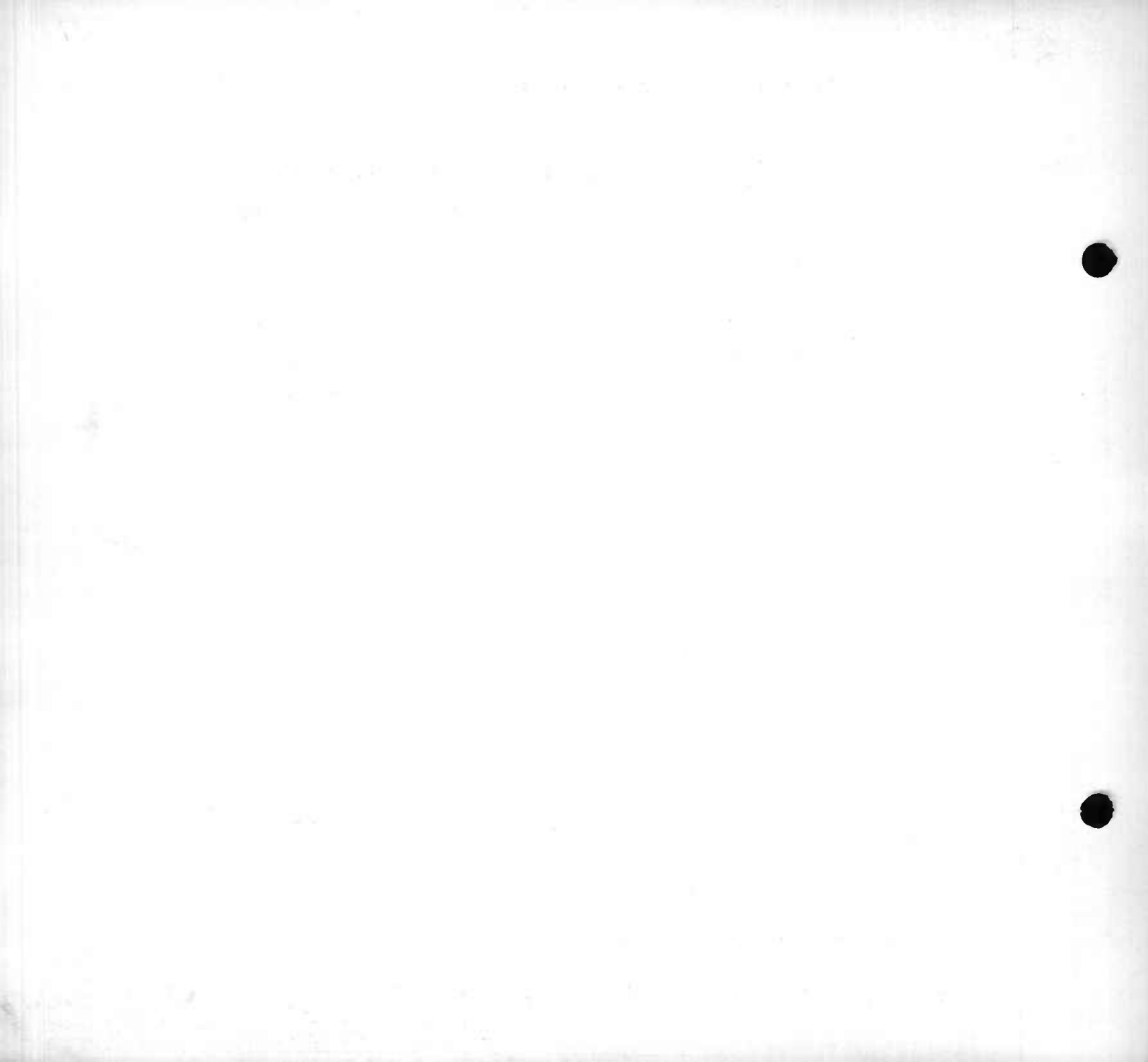
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 69 00527 CERTIFICATE OF DEATH

REG. NO. 69 00527

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Walter Raymond Bacon</u>		2. DATE AND HOUR OF DEATH <u>Jan 8, 1969 15 30 A M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Harford Co 63-00</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u> <u>38</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>ELlicott City</u>	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <u>39 Fells Ave.</u>	
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-4-12</u>	9. AGE (in years last birthday) <u>55</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Walter Bacon</u>				14. MOTHER'S MAIDEN NAME <u>Florence Ebbs.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>EH Chart, Hospital sheet</u>	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>291.0 I</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>hours</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Delirium Tremens</u>	
				(B) <u>Chronic Alcoholism</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Years</u>	
				(C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>Jan 7</u> 19 <u>69</u> to <u>Jan 8</u> 19 <u>69</u> that (1) (we) last saw the deceased alive on <u>Jan 8</u> 19 <u>69</u> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert E. Stoner MD</u> DEGREE				23B. DATE SIGNED <u>Jan 8, 1969</u>	
23C. PHYSICIAN'S NAME (Type) <u>Robert E. Stoner MD</u> DEGREE				23D. ADDRESS <u>University Hospital Balto MD.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1/13/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>BALTO NATIONAL CEM</u>	
24D. LOCATION (City, town, or county) (State) <u>5501 Frederick Ave Baltimore</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 10 1969</u>		25B. NAME OF REGISTRAR <u>Colin E. Taylor</u>		25C. FUNERAL DIRECTOR <u>DONALD E. GLOVER</u>	
				ADDRESS <u>170 N. PATTERSON</u>	





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69 00528 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 00528

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>GEORGE ROSS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>UNKNOWN</b> <b>UNK</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>001148 Low Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 6, 1969 11:30 A.M.</b>	
6. SEX <b>male</b>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>5-01</b>	
7. RACE <b>negro</b>		C. CITY OR TOWN <b>Baltimore</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>JAN 3, 1909</b>		E. STREET AND NUMBER <b>1148 Low St.</b>	
10. AGE (In years last birthday) <b>60</b>		11. BIRTHPLACE (State or foreign country) <b>Buckingham Co. VA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>MATT ROSS</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		15. MOTHER'S MAIDEN NAME <b>SUMANNA BOOKER</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>CORA ROSS 55048 ROVELAND</b>	
18. INFORMANT <b>CORA ROSS</b>		ADDRESS <b>55048 ROVELAND</b>	
19. <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20. DATE OF OPERATION <b>0</b>		21. AUTOPSY? (Yes or No) <b>No</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz</b> M.D. EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> DATE SIGNED <b>1/6/69</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1/10/69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Grt. Albany Cym.</b>		24D. LOCATION (City, town, or county) (State) <b>Cedar Hill</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 16 1969</b>		25B. NAME OF REGISTRAR <b>Donald E. Blower</b>	
25C. FUNERAL DIRECTOR <b>1701 PATTERSON</b>		ADDRESS	

10/11/11  
S. J. G.

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H-620

69 00529 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 00529

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>SAMUEL HARRIS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>January 2, 1969</b> Hour <b>6:10 P.</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 2, 1969 6:10 P.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>JAN 29, 1908</b>		10. AGE (In years last birthday) <b>61</b>	
11. BIRTHPLACE (State or foreign country) <b>SPOUTS SPRING VA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CHARLES HARRIS</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GUARD</b>	
15. MOTHER'S MAIDEN NAME <b>FRITIGERL MARYIE</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>216-10-4440</b>	
17. SOCIAL SECURITY NO. <b>216-10-4440</b>		18. INFORMANT <b>WILLIAM HARRIS 1600 BRADFORD</b>	
19. <b>412.4</b>		CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1/5/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>MT. SHILOH CEMETARY SPOUTS SPRING VA</b>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 16 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>	
25C. FUNERAL DIRECTOR <b>WEST FUNERAL HOME</b>		25D. ADDRESS <b>APPROX 1600 BRADFORD</b>	

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100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

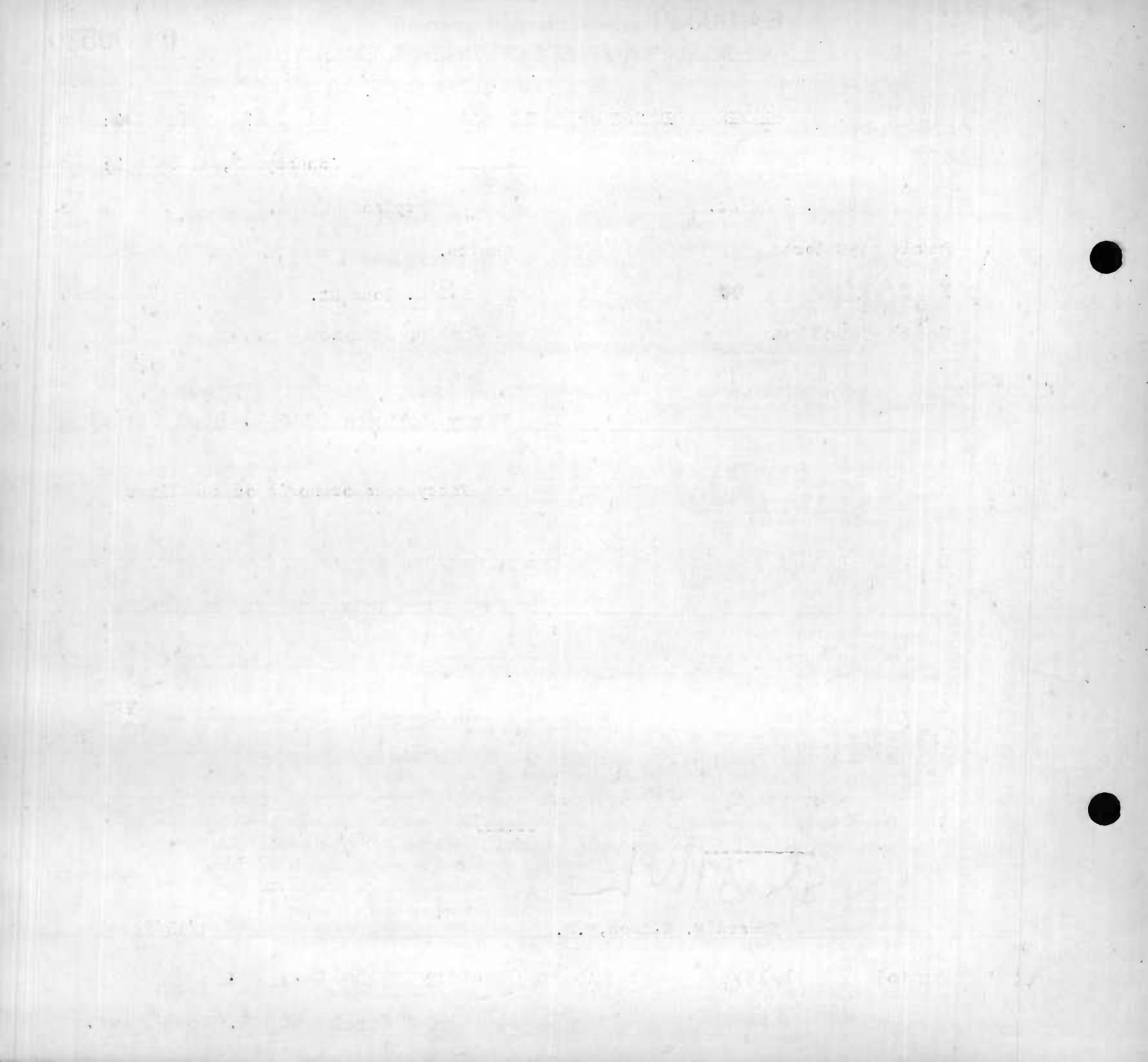
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 00530

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>MINNIE WHITTLEY WHITLEY</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>1 12 69 2:00 p M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>00 908 N. Bond St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 12 1969 2:00 p M.</b>	
6. SEX <b>Female</b>		7. RACE <b>Colored</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>5/17/05</b>		10. AGE (In years last birthday) <b>63</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>Joshua Johnson</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Leroy Johnson</b>		ADDRESS <b>1735 N. Bond Street</b>	
19. CAUSE OF DEATH <b>571.8 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE <b>Fatty metamorphosis of the liver</b> DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) <b>22E. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) <b>YES</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Edward F. Wilson, M.D.</b> M.D. EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b> DATE SIGNED <b>1/13/69</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/16/69</b>	
24C. NAME of CEMETERY or CREMATORY <b>Mt Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 16 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>	
25C. FUNERAL DIRECTOR <b>Wm C March</b>		ADDRESS <b>928 E. North Ave.</b>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Georgiana Conquest</b>		2. DATE AND HOUR OF DEATH <b>1-14-69 4:35 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b> <b>33</b>			A. STATE <b>MARYLAND</b> B. COUNTY <b>8-07</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>1820 E. Oliver Street</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-7-1886</b>	9. AGE (In years last birthday) <b>82</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
13. FATHER'S NAME <b>JAMES TAYLOR</b>			14. MOTHER'S MAIDEN NAME <b>CAROLINE JOHNSON</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mable Fountain 1909 Oakhill Ave</b>
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ASCVD and Congestive Heart Failure</b>			CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Infection - UTI and Leg</b>		<b>2 years</b>
			(B) <b>Ulcers</b>		<b>1 week</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			<b>Chronic hemiparesis 20 old CVA</b>		<b>10 years</b>
			<b>Chronic renal insufficiency - 22 yrs</b>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1-12-69</b> 19 to <b>1-14</b> 19 <b>69</b> that (I) (we) last saw the deceased alive on <b>1-14</b> 19 <b>69</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. Atkinson, MD</b>				23B. DATE SIGNED <b>1-14-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>J. ATKINSON</b>				23D. ADDRESS <b>Johns Hopkins Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1/18/69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt Auburn Cemetery</b>	
24D. LOCATION <b>Balto., Md.</b>		24E. FUNERAL DIRECTOR <b>Wm C. March</b>		24F. ADDRESS <b>928 E. North Ave</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Robert C. Sweeney</b>		25C. ADDRESS	

Received from  
Cigarette Machine Co.  
the sum of \$100.00  
on account of the  
purchase of a  
cigarette machine  
No. 1000  
dated 10/1/50

10

10/1/50  
100.00  
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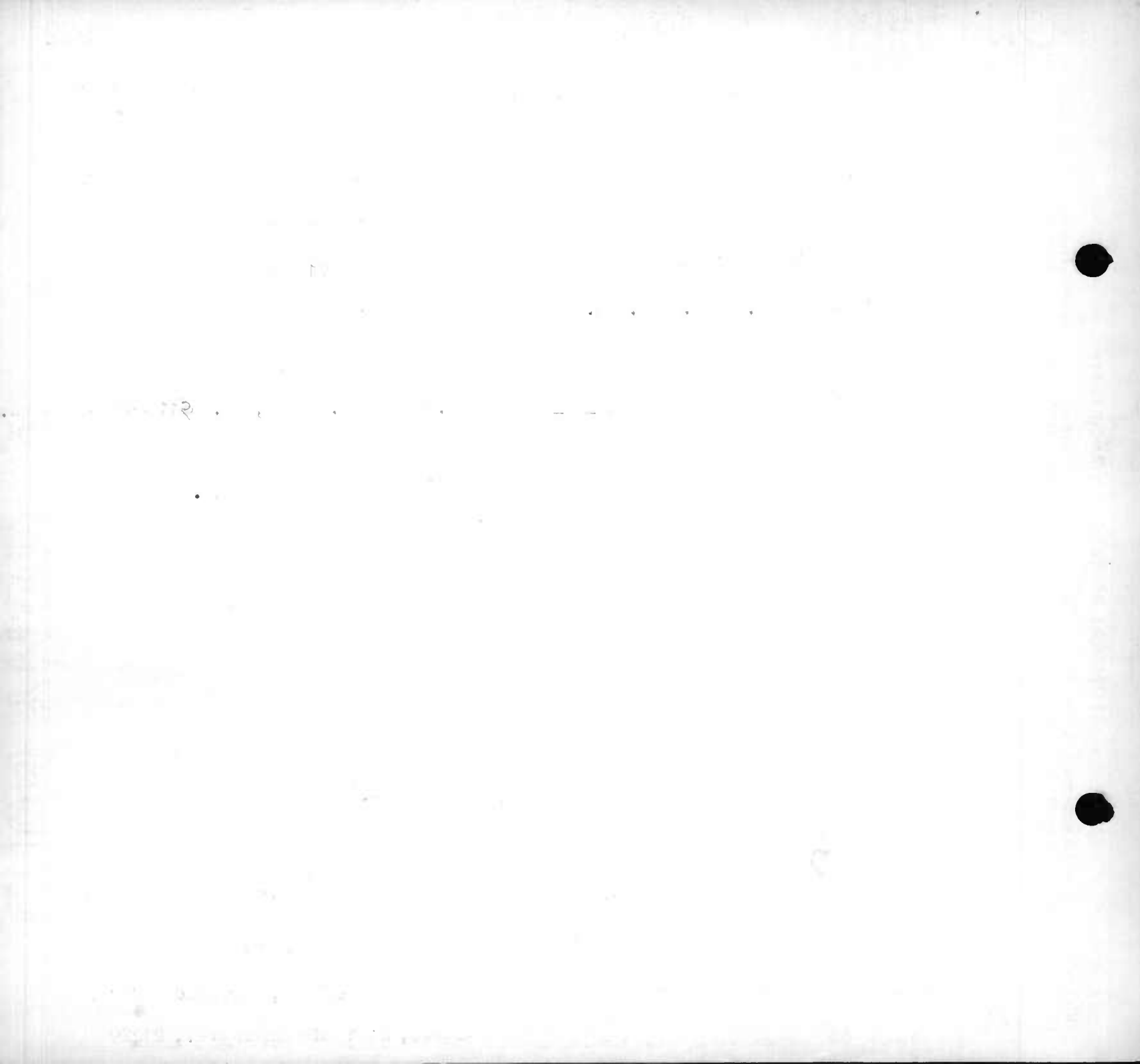
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**FUNERAL DIRECTOR: IMPORTANT**

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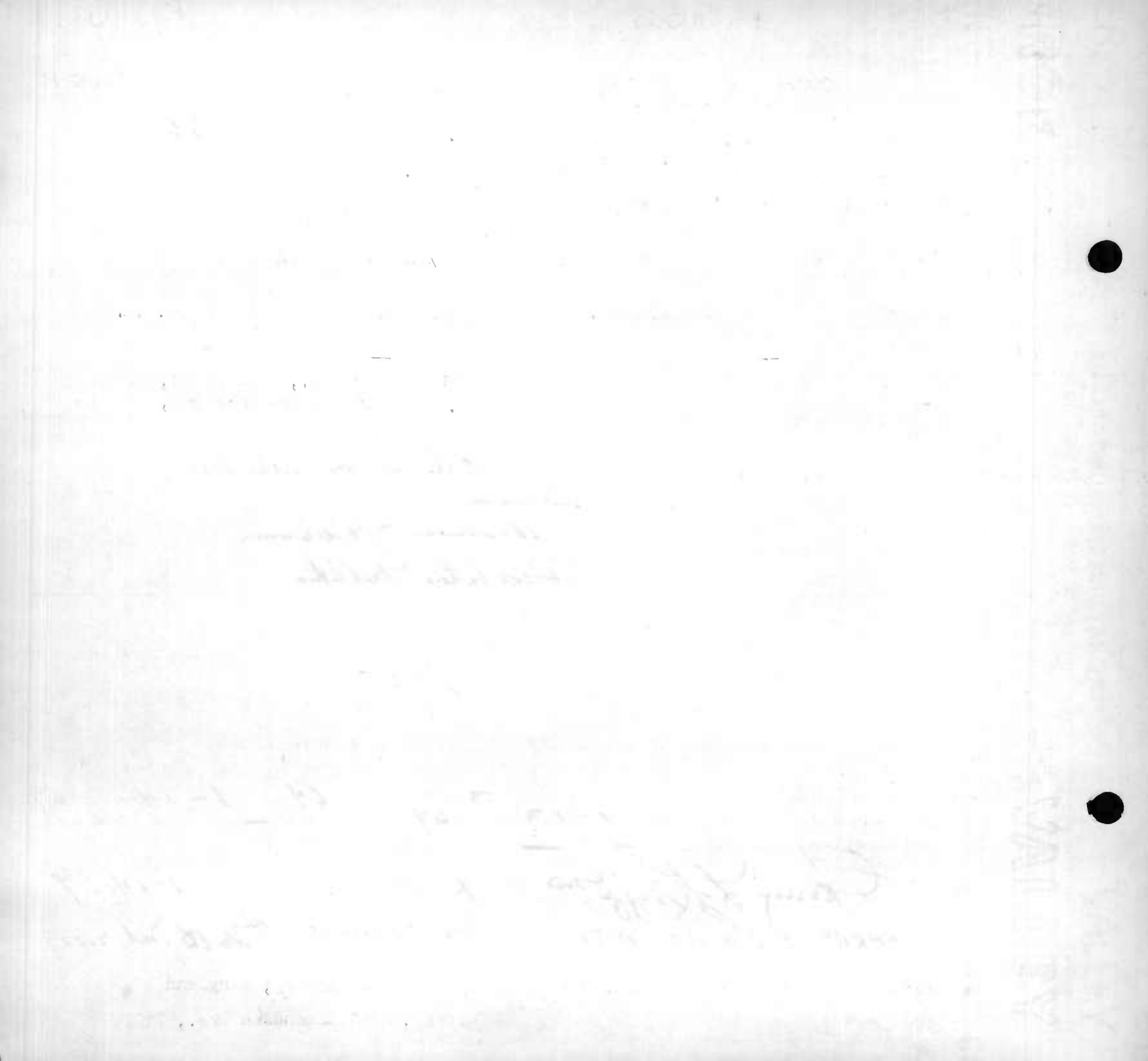
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>69 00532</u>	
BIRTH NO. <u>P-500</u>		69 00532	
1. NAME OF DECEASED (Type or Print) <u>Joseph Anthony Payne</u>		2. DATE AND HOUR OF DEATH <u>JAN 13, 1969</u> <u>8<sup>30</sup> A M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University of Md. Hospital</u> <u>38</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>594 Jannycake Rd</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/7/47</u> 9. AGE (in years last birthday) <u>71</u> <del>5000</del>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>A &amp; P Co.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>A. &amp; P. Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Andrew Payne</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Bizzogger</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>216-09-2880A</u>	
17. INFORMANT <u>Mrs. Joseph A. Payne, Sr.</u>		ADDRESS <u>511 Jannycake Rd.</u>	
18. <u>146.0</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Squamous cell carcinoma of Tonsil &amp; Tongue</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>2</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>Yes</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Dec</u> 19 <u>68</u> to <u>JAN 13</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>JAN 13</u> 19 <u>69</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Leighton Siegel M.D.</u>		23B. DATE SIGNED <u>1/13/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>Leighton Siegel M.D.</u>		23D. ADDRESS <u>University of Md. Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>1/17/69</u>	24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland 21229</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 16 1969</u>	25B. NAME OF REGISTRAR <u>P. J. S. Fickel</u>	25C. FUNERAL DIRECTOR ADDRESS <u>Witzke, 4101 Edmondson Ave., 21229</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

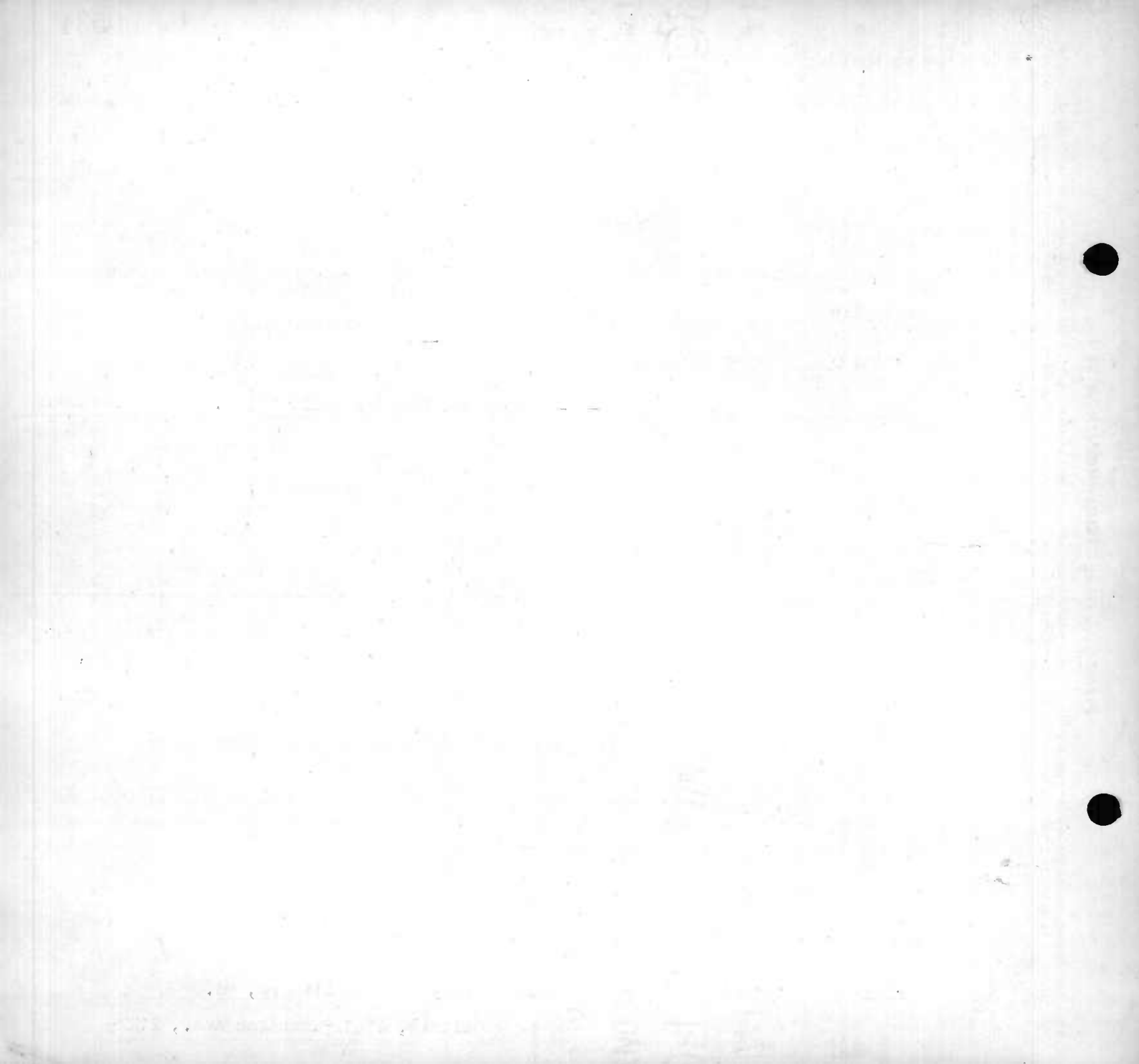
BIRTH NO. <span style="float: right;">D-500</span>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="float: right;">6 00533</span>	
1. NAME OF DECEASED (Type or Print) <b>ORA E. DUNN</b>				2. DATE AND HOUR OF DEATH <b>JAN 14, 1969 6:45 P. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 Hood's Nursing Home Edmondson &amp; North Bond Road</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Balto</b> C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>4608 Manordene Road</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/28/04</b>	9. AGE (In years lost birthday) <b>64</b>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Social Security</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>—</b>				14. MOTHER'S MAIDEN NAME <b>—</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>7316 Baylor Ave., College Pk, Md Mrs. Middleton "Vaughn" McAbee,</b>			
18. <b>250.9 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>arteriosclerotic Cardio Vasc. Disease -</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) <b>Anemia - &amp; leukemia</b> (C) <b>Diabetes mellitus</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>3-9-1964</b> to <b>1-14-1969</b> . that (I) ( <del>we</del> ) last saw the deceased alive on <b>1-13-1969</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <b>Harry A. Knipp, MD.</b>				23B. DATE SIGNED <b>1-14-69</b>		23C. PHYSICIAN'S NAME (Type) <b>HARRY A. KNIPP, M.D.</b>	
23D. ADDRESS <b>4116 Edmondson Ave. Balto, Md. 21229</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					
24B. DATE <b>1/17/69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 16 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Witzke, 4101 Edmondson Ave., 21229</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">6: 00534</span>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="float: right;">6: 00534</span>	
1. NAME OF DECEASED (Type or Print) <i>Mrs HELEN STICHEL</i>		2. DATE AND HOUR OF DEATH <i>1. 14. 1969</i> <span style="float: right;">9 P.M.</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>34 Bon Secours Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>28-54</i>			
		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <i>5313 Edmondson Ave.</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>8-24-86</i>	9. AGE (In years last birthday) <i>82</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
13. FATHER'S NAME <i>Charles Stephen</i>		14. MOTHER'S MAIDEN NAME <i>---</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>216-05-1569D</i>		17. INFORMANT ADDRESS <i>Mrs. Charles Wall, 615 N. Nottingham Road</i>	
18. <i>153.8</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Metastatic carcinoma in liver</i> (B) <i>adenocarcinoma of colon</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>---</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>months</i> <i>months</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<i>Encephalomalacia, retrocerebral cortex</i> <i>years</i>			
19A. DATE OF OPERATION <i>8/13/69</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12-30-1968</i> to <i>1-14-1969</i> , that (I) (we) lost saw the deceased alive on <i>1-14-1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>M. Keyhani M.D.</i>				23B. DATE SIGNED <i>1. 14. 69</i>	
23C. PHYSICIAN'S NAME (Type) <i>M. KEYHANI M.D.</i>				23D. ADDRESS <i>BON SECOURS Hosp.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/18/69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Lorraine Park Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <i>Robert E. J...</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Witzke, 4101 Edmondson Ave., 21229</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-251		69 00535 BALTIMORE CITY HEALTH DEPARTMENT		69 00535	
CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		W. MARGARET AIKEN		1/13/69 8:35 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSPITAL 601 N. BROADWAY ST BALTIMORE, MD 21205				A. STATE MARYLAND B. COUNTY 27-12	
5. SEX F		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 2/22/94	
RETIRED - NONE		RETIRED		9. AGE (In years last birthday) 74	
13. FATHER'S NAME LOUIS WIRTH		14. MOTHER'S MAIDEN NAME MARGARET GRAY		11. BIRTHPLACE (State or foreign country) Cincinnati, Ohio	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-03-2618		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
17. INFORMANT Mr. Newton Aiken				ADDRESS (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 615.21 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hrs.	
(A) IMMEDIATE CAUSE MYOCARDIAL FAILURE DUE TO, OR AS A CONSEQUENCE OF:					
(B) HYPERTENSION, PROBABLE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF:					
(C) POST-OP REMOVAL OF 60 LB. ABDOMINAL CYST C INTESTINAL OBSTRUCTION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION JAN. 11, 1969		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PARA-OVARIAN CYST		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 1/6 19 69 to 1/13 19 69 that (1) (yes) last saw the deceased alive on 1/13 19 69 and that (in my) (not) opinion death occurred on the date and hour and from the causes stated above (1) (yes) (did) (did not) view the body after death.					
23A. SIGNATURE Vernon Tolo, M.D.				23B. DATE SIGNED Jan. 13, 1969	
23C. PHYSICIAN'S NAME (Type) DR. VERNON TOLO M.D.				23D. ADDRESS JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/16/69		24C. NAME OF CEMETERY OR CREMATORY Quaker-Bottom, Friends	
25A. DATE REC'D BY HEALTH DEPT. JAN 16 1969		25B. NAME OF REGISTRAR H.W. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 6-00536	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Michael K. Cochran</b>		2. DATE AND HOUR OF DEATH <b>Jan. 13, 1969 3:20 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> 8. COUNTY <b>Balt.</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 Union Memorial Hosp.</b>		E. STREET AND NUMBER <b>5935 Radecke Ave.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/19/43</b>	9. AGE (In years last birthday) <b>25</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Blue Cross Assoc. Coordinator</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Medicare</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>STIRLING Henry Cochran</b>		14. MOTHER'S MAIDEN NAME <b>Eleanor Kearney</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-40-7513</b>		17. INFORMANT <b>MRS. MARY A. COCHRAN (SAME)</b>	
18. <b>20-0-91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Pulmonary Edema</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Nephrosclerosis</b> <b>Diabetic Nephropathy</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Diabetic Nephropathy</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>cd.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 2</b> 1969 to <b>Jan 13</b> 1969, that (I) (we) last saw the deceased alive on <b>Jan 13</b> 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Charles Robert Goshen MD.</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>1/13/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>CHARLES ROBERT GOSHEN MD.</b>		23D. ADDRESS <b>UNION MEM. HOSP. BALTO. MD. 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/13/69</b>		24C. NAME of CEMETERY or CREMATORY <b>St. John's Longgreen</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore County, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 16 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd Balto. 12, Md.</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

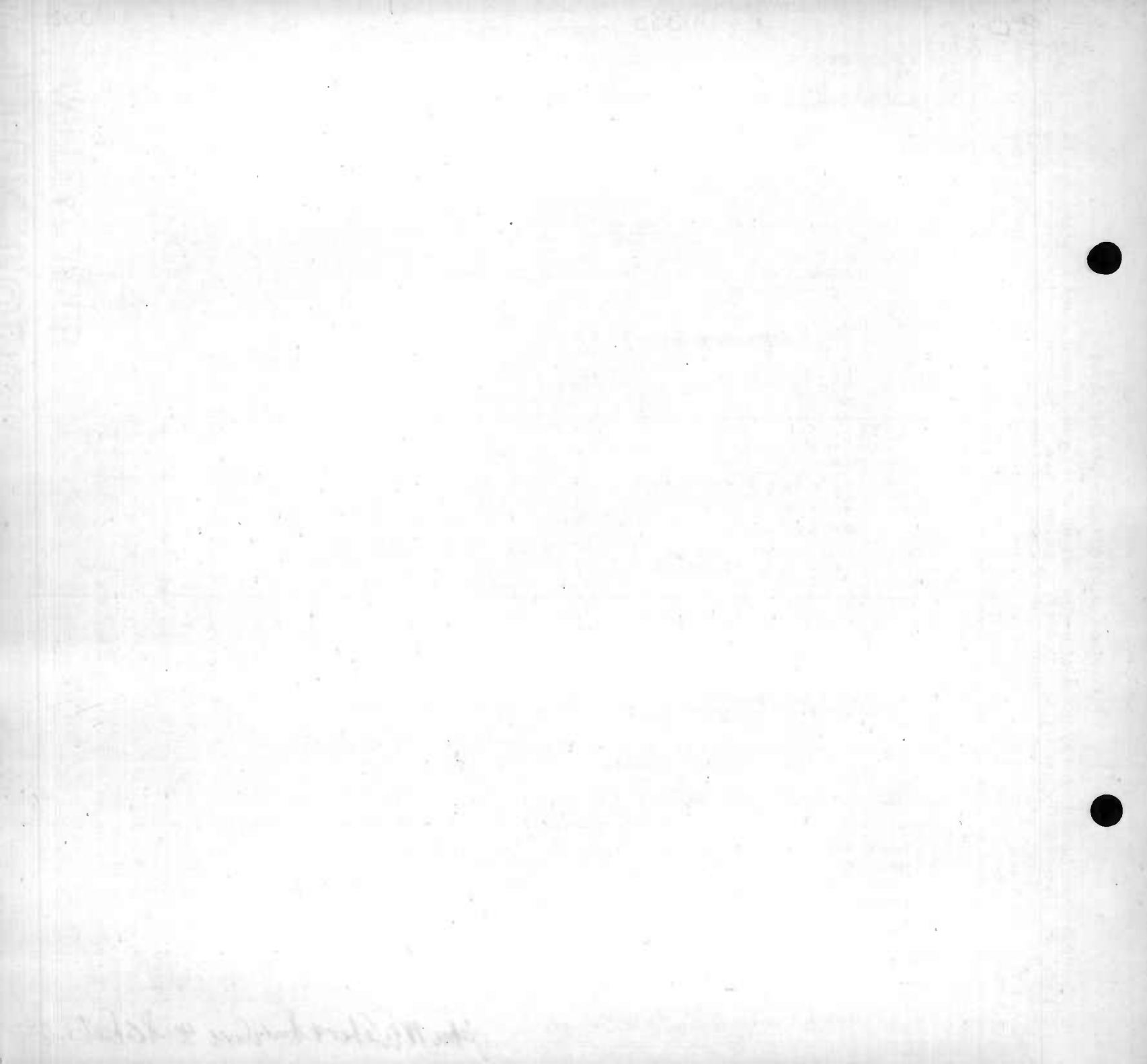
BIRTH NO. 10220		69 00537		CERTIFICATE OF DEATH		REG. NO. 69 00537	
1. NAME OF DECEASED (Type or Print) <b>STANLEY LEO MYSZKOWSKI</b>				2. DATE AND HOUR OF DEATH <b>1-13-69</b> <b>2:52 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>31 BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVE.</b> <b>BALTIMORE, MARYLAND #21224</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1-02</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b># 621 S. DECKER AVE. BALTIMORE, MD. 21224</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-8-04</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>BETH. STEEL CO.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MICHAEL MYSZKOWSKI (DECEASED)</b>				14. MOTHER'S MAIDEN NAME <b>MARYANNA BLASKOWSKA (DECEASED)</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-07-7151</b>		17. INFORMANT ADDRESS <b>4940 EASTERN AVE. BCH: RECORDS BALTIMORE, MD. #21224</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>2-8-80 X</b> <b>VENTRICULAR ARREST</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> <b>DIABETES MELLITUS</b> <b>SUPRA VENTRICULAR TACHYCARDIA</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b> <b>4 1/2 days</b> <b>6 days</b> <b>?-unknown 6 days</b>			
19A. DATE OF OPERATION <b>1/17/69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>(B) SKULL FRACT (C) SUBDURAL</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>IN HOUSE</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>COUSIN'S HOME 00-00</b>			
21D. TIME OF INJURY (APPROX.) <b>1 7 69 5:00 P.M.</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>PT. BECAME DIZZY AND FELL DOWN STAIRS</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>JANUARY 7 1969</b> to <b>JANUARY 13 1969</b> , that (I) (we) last saw the deceased alive on <b>JANUARY 13, 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>John E. Yount M.D.</b>				23B. DATE SIGNED <b>1/13/69</b>		23C. PHYSICIAN'S NAME (Type) <b>JOHN E. YOUNT MD.</b>	
23D. ADDRESS <b>BALTIMORE CITY HOSPITALS #21224</b> <b>4940 EASTERN AVE. BALTIMORE MD.</b>		24. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>					
24B. DATE <b>1-17-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>SACRED HEART OF JESUS</b>		24D. LOCATION (City, town, or county) (State) <b>DUNDLAK, MARYLAND</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 16 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Tabor</b>		25C. FUNERAL DIRECTOR <b>John M. Weber &amp; Sons Inc. S. Chester</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.
6-00538				6-00538
BIRTH NO.				
1. NAME OF DECEASED (Type or Print) <b>ALEXANDER J. Sumowski</b>			2. DATE AND HOUR OF DEATH <b>Jan. 14, 1969 10:10 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>NORTH CHARLES GEN. Hospital</b> <b>49</b>			A. STATE <b>MARYLAND</b>	
			B. COUNTY <b>1-05</b>	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			C. CITY OR TOWN <b>BALTIMORE</b>	
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b>			6. RACE <b>W</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			8. DATE OF BIRTH <b>3-14-01</b>	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. AGE (In years last birthday) <b>67</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FACTORY WORKER</b>			10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE AdELBERT</b>			14. MOTHER'S MAIDEN NAME <b>Johanna Wisniewski</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>213-03-8109</b>	
17. INFORMANT <b>LOTTIE Sumowski</b>			ADDRESS <b>SAME</b>	
18. <b>209 X 1</b> CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				
ANTECEDENT CAUSES				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
(A) IMMEDIATE CAUSE <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF:				
(B) <b>Anemia, severe</b> DUE TO, OR AS A CONSEQUENCE OF:				
(C) <b>Myelofibrosis</b>				
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>Dec. 30, 1968</b> to <b>JAN. 14, 1969</b> , that (I) (we) last saw the deceased alive on <b>JAN. 14, 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Adoracion B. Paulino</b> DEGREE				23B. DATE SIGNED <b>JAN. 14, 1969</b>
23C. PHYSICIAN'S NAME (Type) <b>Adoracion B. PAULINO</b> DEGREE				23D. ADDRESS <b>NORTH CHARLES GEN. Hospital</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-18-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>HOLY ROSARY CEMETERY</b>
24D. LOCATION (City, town, or county) (State) <b>DUNDALK MARYLAND</b>				
25A. DATE RECEIVED BY HEALTH DEPT. <b>JAN 16 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Faltus</b>		25C. FUNERAL DIRECTOR <b>John W. Scher &amp; Sons Inc 401 S. Chester St</b>
ADDRESS				



# FUNERAL DIRECTOR: IMPORTANT

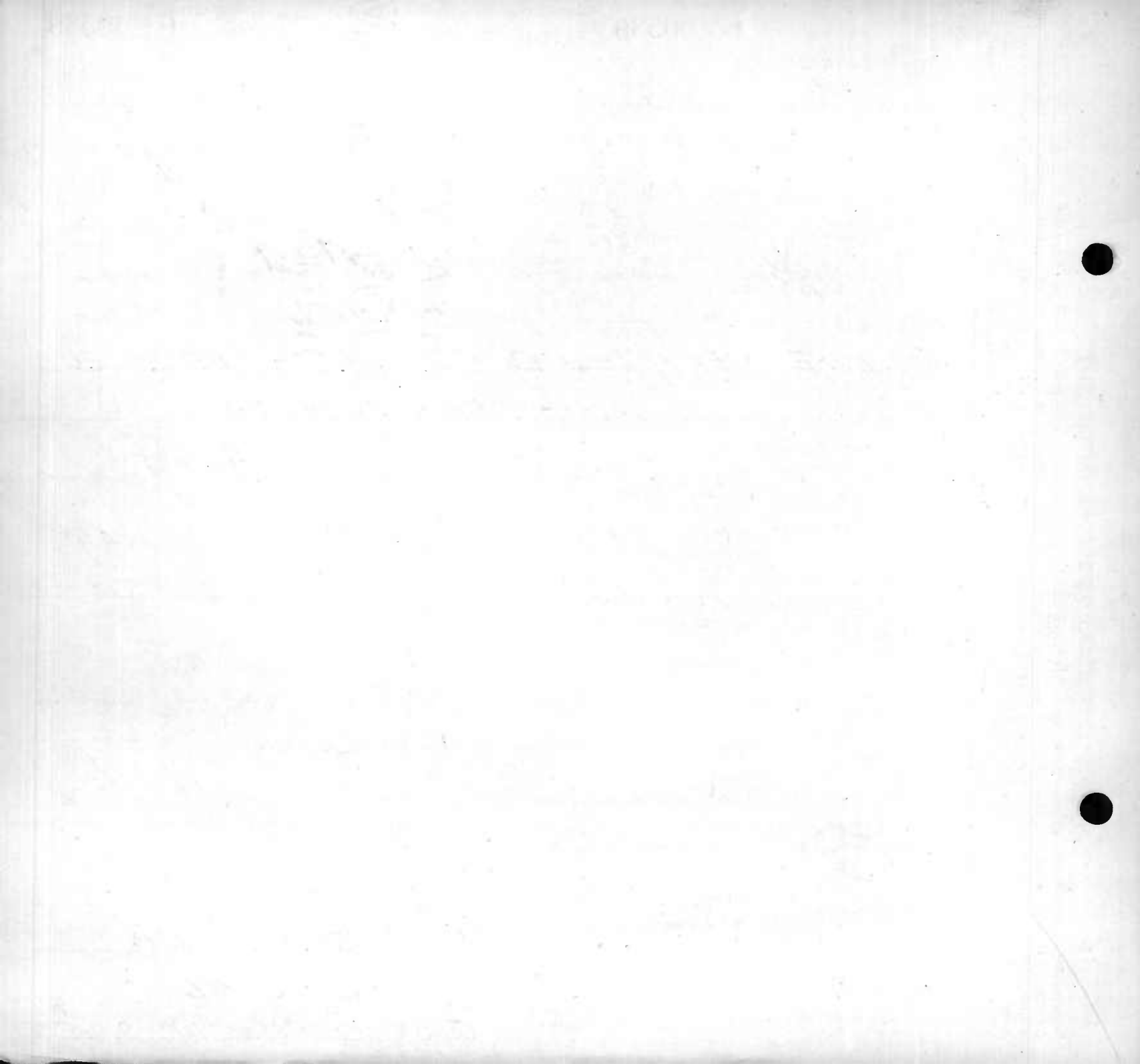
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 6 00539

BIRTH NO. 6 00539		1. NAME OF DECEASED (Type or Print) <b>Koenig George</b>		2. DATE AND HOUR OF DEATH <b>1/15/69 1:15 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>44 Union Mem Hosp</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO E. STREET AND NUMBER <b>3320 Keswick Rd 13-06</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/29/07 61</b>	9. AGE (In years & 1 birthday)	10. If Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>THEODORE KOENIG (DECEASED)</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH (DECEASED)</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-054369</b>		17. INFORMANT <b>SR. MARY JOVITA</b>	
18. <b>569.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiac Arrest</b> (B) <b>Massive GI hemorrhage</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A) _____					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTO. SY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1/15/69</b> to <b>1/15/69</b> , that (I) (we) last saw the deceased alive on <b>1/15/69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Barry Weckesser</b>		23B. DATE SIGNED <b>1/15/69</b>		23C. PHYSICIAN'S NAME (Type) <b>BARRY WECKESSER M.D.</b>	
23D. ADDRESS <b>UNION MEMORIAL HOSP</b>		23E. DEGREE <b>MD</b>		23F. SPECIALTY <b>INTERNAL MEDICINE</b>	
24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) <b>BURIAL 1-18-69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>HOLY REDEEMER CEM BALTO MD</b>		24D. LOCATION (City, town, or county) (State) <b>S. CHESTER</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 16 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>JOHN M. WEBER &amp; SONS INC</b>	





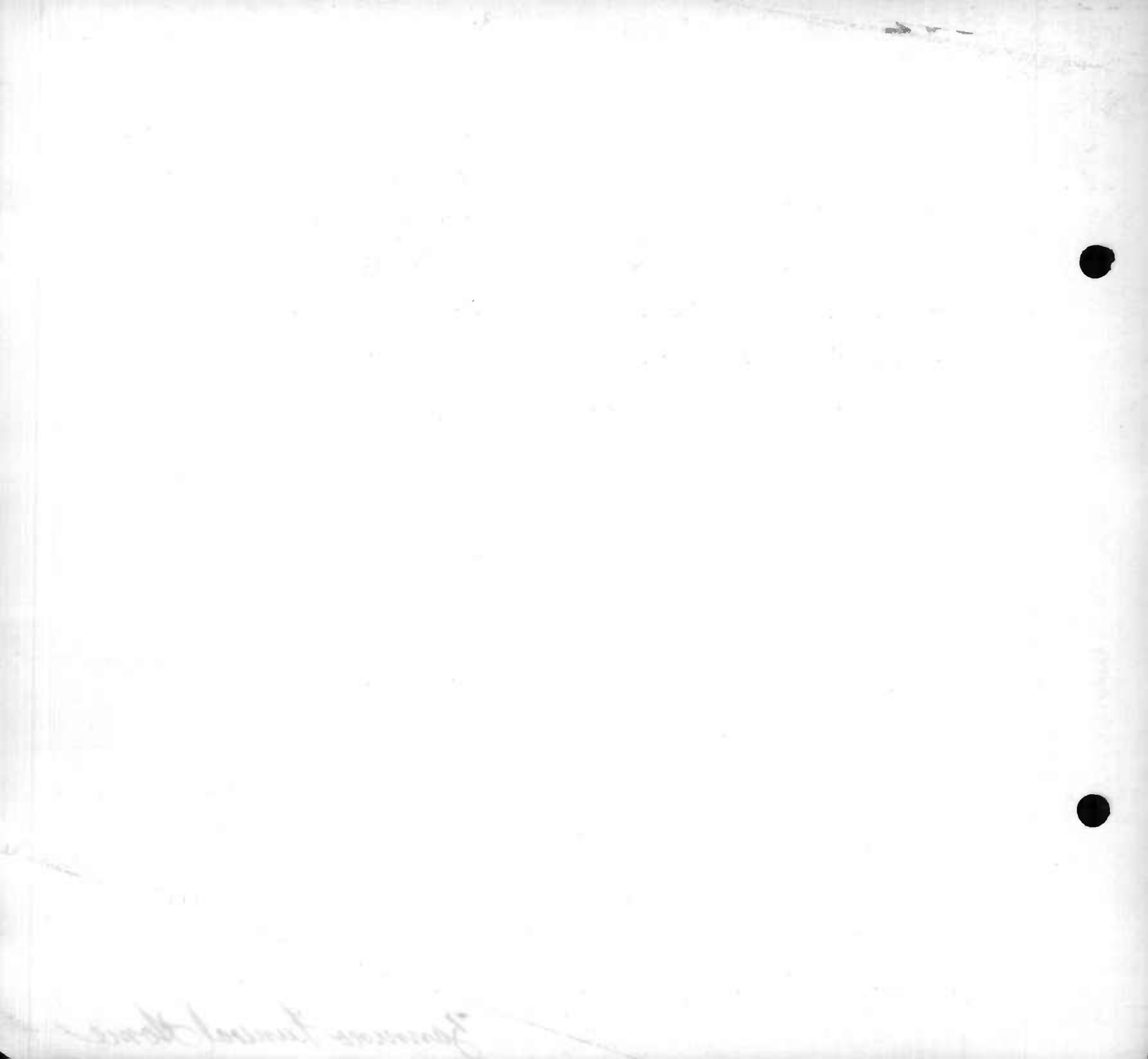


197063  
PETERSON, CECIL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 61 00540	
1. NAME OF DECEASED (Type or Print) Cecilia Peterson		2. DATE AND HOUR OF DEATH 1/13/69 10 <sup>10</sup> A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE md B. COUNTY 1-01			
5. SEX F		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY HOME		8. DATE OF BIRTH 11/08/11 57	
13. FATHER'S NAME Peter Staniewicz		14. MOTHER'S MAIDEN NAME Helen Mateja		9. AGE (in years last birthday) 57	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. 218-09-0133		11. BIRTHPLACE (State or foreign country) BALTIMORE MD	
17. INFORMANT Mrs Patricia Wagner		ADDRESS 1 BRANCH ST.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 441.21 RUPTURE OF ABDOMINAL AORTIC ANEURYSM		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Rupture of abdominal aortic aneurysm 46 hrs		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 46 hrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF: Aneurysm of abd aorta			
(C) DUE TO, OR AS A CONSEQUENCE OF: Atherosclerosis + hypertension					
19A. DATE OF OPERATION 3 11/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured abdominal aortic aneurysm		20A. AUTOPSY? (Yes or No) Yes (limited)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/11/69 to 1/13/69 that (I) (we) last saw the deceased alive on 1/13/69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert S. Kurtz MD		23B. DATE SIGNED 1/13/69		23C. PHYSICIAN'S NAME (Type) Robert S Kurtz MD	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JAN 17, 1969		24C. NAME OF CEMETERY OR CREMATORY Holy Rosary Cem	
24D. LOCATION German Hill Rd Balt MD		25A. DATE RECEIVED BY HEALTH DEPT. JAN 16 1969		25B. NAME OF REGISTRAR Robert E. Farkas	
25C. FUNERAL DIRECTOR Zamunda Funeral Home		25D. ADDRESS			

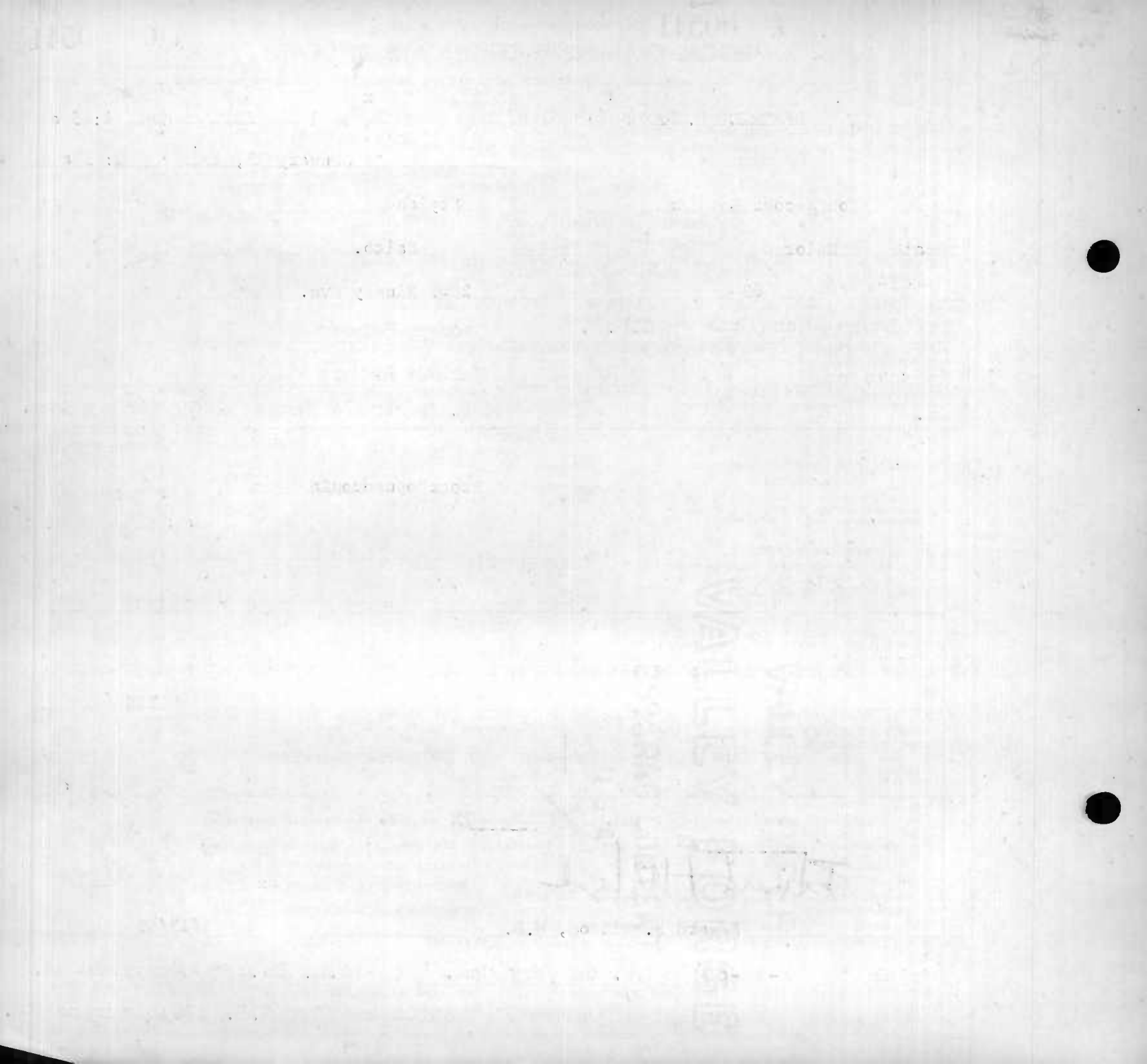


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
BEATRICE E. RAMOS (Barnes)		Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year		January 13, 1969		1:45 a.m.	
FULL NAME OF HOSPITAL OR INSTITUTION		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?		A. STATE B. COUNTY	
34 Bon secour Hospital		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		10-02	
6. SEX		7. RACE		9. DATE OF BIRTH		10. AGE (In years lost birthday)		11. BIRTHPLACE (State or foreign country)	
Female		Colored		6-22-1905		63		Baltimore, Maryland	
12. CITIZEN OF		13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME	
U.S.A.		George Barnes		Unemployed				Hannah Barnes	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS		19. CAUSE OF DEATH	
No.				Mrs. Gertrude Ramos		2809 Kinsey Ave.		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	
								(A) IMMEDIATE CAUSE	
								DUE TO, OR AS A CONSEQUENCE OF:	
								(B) DUE TO, OR AS A CONSEQUENCE OF:	
								(C) DUE TO, OR AS A CONSEQUENCE OF:	
								OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)					
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?					
22D. TIME (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?					
OF INJURY (APPROX.)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							
23.									
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED					
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER							
Edward F. Wilson, M.D.		ASSOCIATE MEDICAL EXAMINER							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		1-16-69		Mt. Calvary Cem.		A.A. Co., Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JAN 16 1969		R. E. F. F. F.		MORTON & DYETT F.H.		1701 Laurens St.			



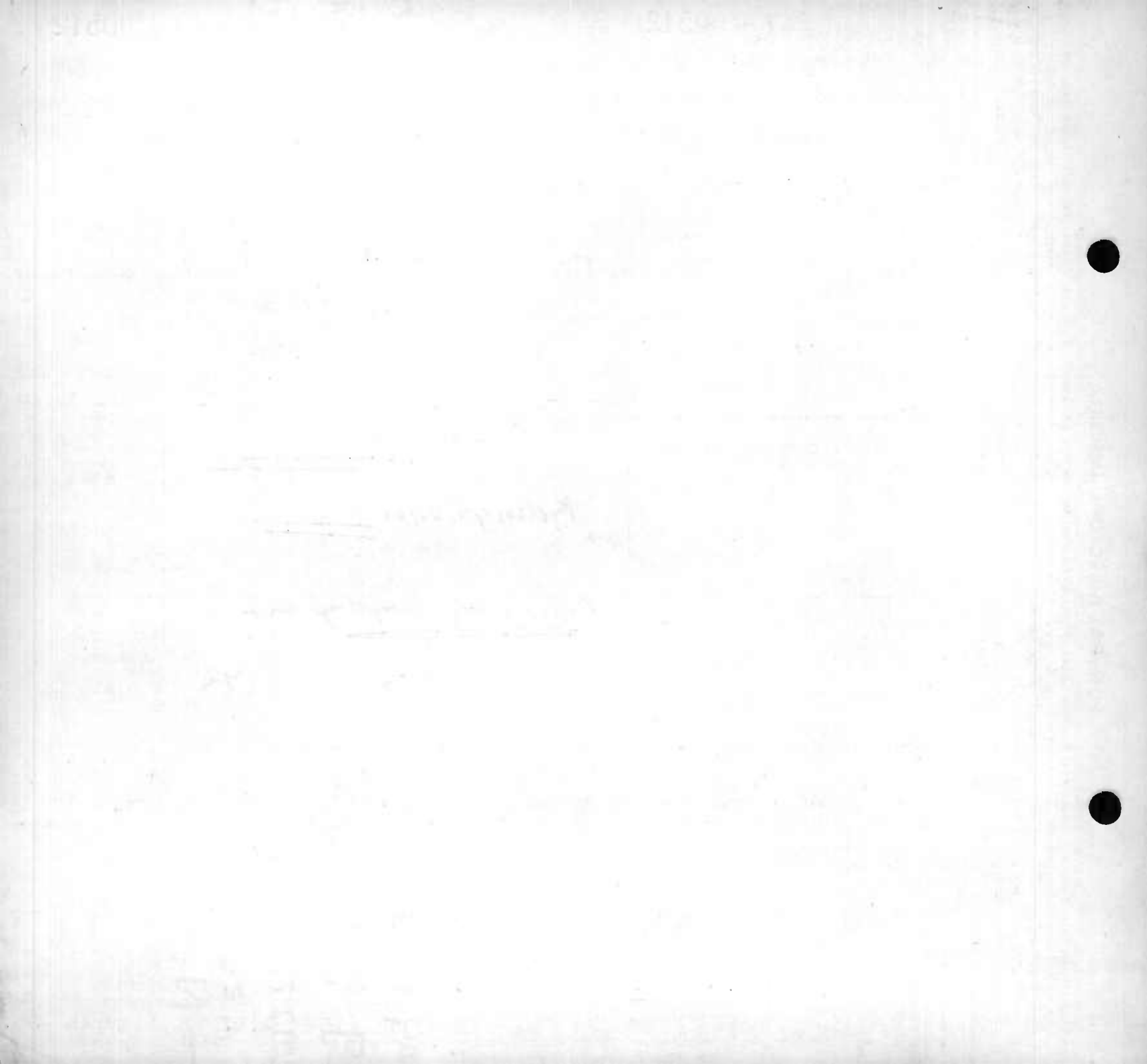
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 63 00542

BIRTH NO. 63 00542		1. NAME OF DECEASED (Type or Print) <u>Lynne E. Ehney</u>		2. DATE AND HOUR OF DEATH <u>1-12-69</u> <u>6:30 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO.</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 Maryland Canal Hosp.</u>			C. CITY OR TOWN <u>BALTO.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <u>425 Mansie Ct.</u>		
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>02-25-00</u>		9. AGE (In years last birthday) <u>68</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
13. FATHER'S NAME <u>MISSING N/A</u>			14. MOTHER'S MAIDEN NAME <u>Dolly Roine</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>			16. SOCIAL SECURITY NO. <u>218-01-3484</u>		17. INFORMANT <u>Admin sheet</u> ADDRESS <u>Mrs. Mary Cook 924 N. Central Avenue</u>
18. <u>590.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Uremia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Pyelonephritis</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Gout</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Acute</u> (C) <u>Pulmonary Embolism</u>		
19A. DATE OF OPERATION <u>2</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) <u>Yes</u>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>1/12/69</u> to <u>1/13/69</u> that (I) (we) last saw the deceased alive on <u>1/12/69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>G.M. Dempsey M.D.</u>			23B. DATE SIGNED <u>1/13/69</u>		
23C. PHYSICIAN'S NAME (Type) <u>G.M. Dempsey M.D.</u>			23D. ADDRESS <u>MCH</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-16-69</u>	24C. NAME of CEMETERY or CREMATORY <u>Mount Auburn Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 16 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR ADDRESS <u>MORTON &amp; DYETT F.H. 1701 Laurens St.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 6 00543

BIRTH NO.		6 00543	
1. NAME OF DECEASED (Type or Print)		TAYLOR, ROSA B. x (ROSE)	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH 1/13/69 12 35 P M.	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND Baltimore 53-00	
33 JOHNS HOPKINS HOSPITAL.		C. CITY OR TOWN BALTIMORE	
		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER 541 NEW PITTSBURGH AVENUE 21222	
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-15-22
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 46
NONE		HOUSEWIFE	11. BIRTHPLACE (State or foreign country) North Carolina
13. FATHER'S NAME WALTER RIFFIN		12. CITIZEN OF WHAT COUNTRY U.S.A.	
14. MOTHER'S MAIDEN NAME ADDIE BULLOCK		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No.	
16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Herbert Taylor	
		ADDRESS 541 New Pittsburg	
18. CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE RENAL Failure DUE TO, OR AS A CONSEQUENCE OF: 2 1/2 years	
		(B) Chronic Glomerulo nephritis DUE TO, OR AS A CONSEQUENCE OF: not exactly known ~10 years	
		(C) -	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Gram Negative Sepsis 2 days			
19A. DATE OF OPERATION 0 -		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan 5 1969 to 235 Jan 13 1969 that (I) (we) last saw the deceased alive on Jan 13 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Stephen H. Polmar M.D.		23B. DATE SIGNED 1/13/69	
23C. PHYSICIAN'S NAME (Type) STEPHEN H. POLMAR M.D.		23D. ADDRESS JOHNS HOPKINS HOSPITAL, BALT, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 1-18-69	24C. NAME OF CEMETERY OR CREMATORY Hasadah Bapt Ch. Cem.	24D. LOCATION (City, town, or county) (State) Jarrett, Virginia
25A. DATE RECEIVED JAN 18 1969		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR MORTON & DYETT F.H.		ADDRESS 1701 Laurens St.	

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6 00544 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6 00544

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>JOHN THOMAS (THOMPSON)</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <b>1</b> Day <b>15</b> Year <b>69</b> Hour <b>12:35 a</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b> <b>1811 Vine St. D.O.A.</b>		3. DATE PRONOUNCED DEAD Month <b>January</b> Day <b>15</b> Year <b>1969</b> Hour <b>12:35 a</b> M.	
6. SEX <b>Male</b> 7. RACE <b>Colored</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>20-01</b>	
9. DATE OF BIRTH <b>9-7-01</b> 10. AGE (In years lost birthday) <b>67</b> 11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		E. STREET AND NUMBER <b>1811 Vine St.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unkn</b>		13. FATHER'S NAME <b>Unkn</b>	
14B. KIND OF BUSINESS OR INDUSTRY <b>Unkn</b>		15. MOTHER'S MAIDEN NAME <b>Unkn</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>217168621</b>	
18. INFORMANT <b>Henrietta Gaines</b>		ADDRESS <b>1811 W. Vine St. Baltimore, Md.</b>	
19. <b>1990</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Metastatic carcinoma site undetermined</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB-UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Edward F. Wilson</b> M.D. EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b>  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>  DATE SIGNED <b>1/15/69</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-18-69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 16 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>	
25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT FUNERAL HOMES, INC.</b>		ADDRESS <b>1701 Laurens St., Balto., Md. 21217</b>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>63 00545</b>
BIRTH NO. <b>63 00545</b>				CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) <b>A. PERCY GOLDMAN</b>		2. DATE AND HOUR OF DEATH <b>JANUARY 16, 1969</b> <b>5</b> A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>BELVEDERE NURSING HOME</b> <b>90</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>27-55</b>		
5. SEX <b>MALE</b> 6. RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <b>6-14-1903</b>		9. AGE (In years last birthday) <b>65</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OPTOMETRIST</b>		11. BIRTHPLACE (State or foreign country) <b>CANADA</b>		
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <b>CANADA</b>		
13. FATHER'S NAME <b>JOSEPH GOLDMAN</b>		14. MOTHER'S MAIDEN NAME <b>MINNIE ?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		
17. INFORMANT <b>DR. EDWIN GOLDMAN, 2207 ARDEN ROAD #21209</b>		ADDRESS <b>#21209</b>		
18. <b>150X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Ca 9 Asphyxias</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 69</b> to <b>Jan 16</b> 19 <b>69</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>Jan 69</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> <del>(did)</del> (did not) view the body after death.				
23A. SIGNATURE <b>Joseph B. Gross</b>		23B. DATE SIGNED <b>Jan 16 1969</b>		23C. PHYSICIAN'S NAME (Type) <b>DR. JOSEPH B. GROSS</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-19-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>SHAAREI ZEDEK</b>
24D. LOCATION (City, town, or county) (State) <b>ST. JOHN, NEW BRUNSWICK, CANADA</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 16 1969</b>		
25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>		

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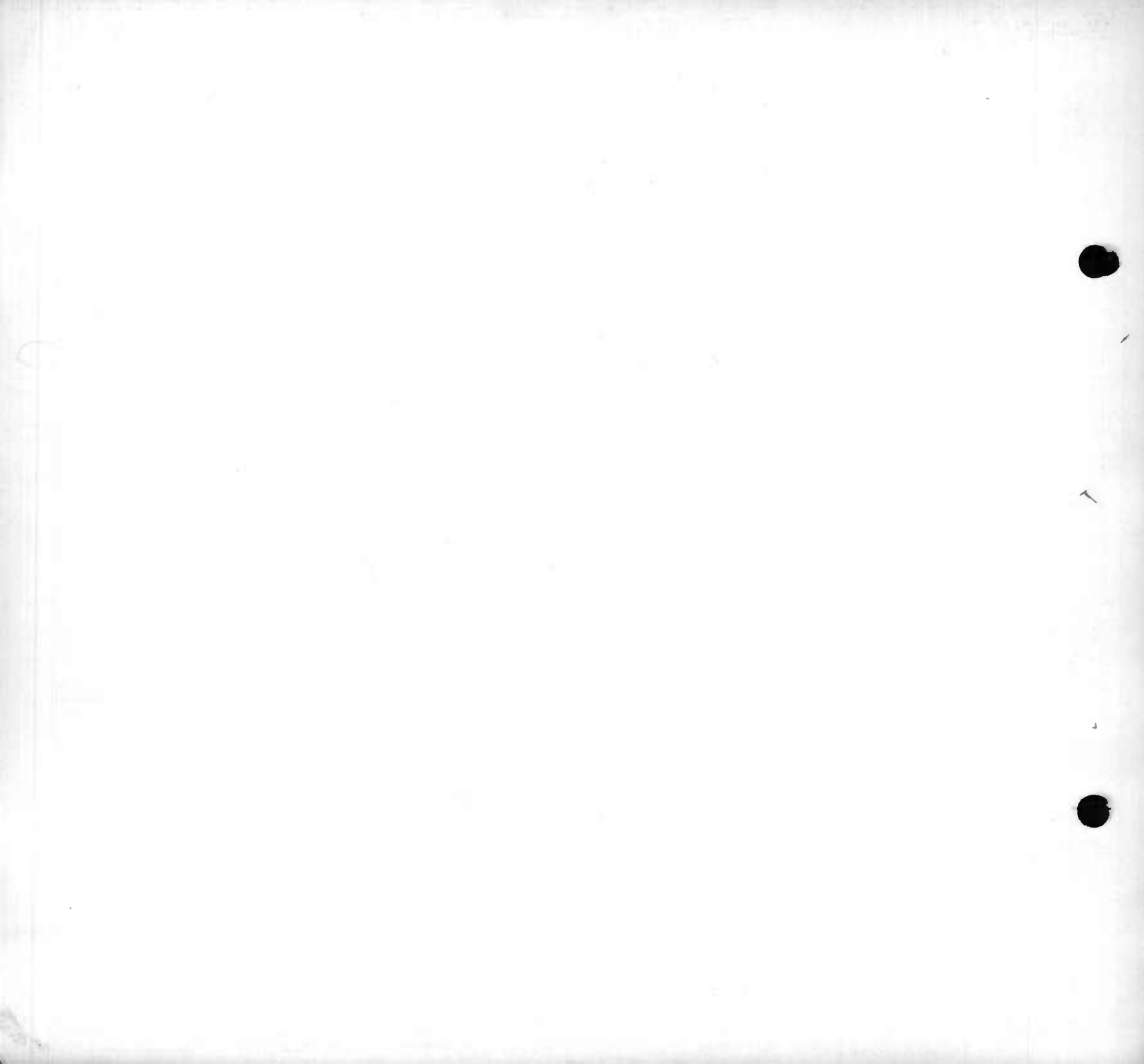
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

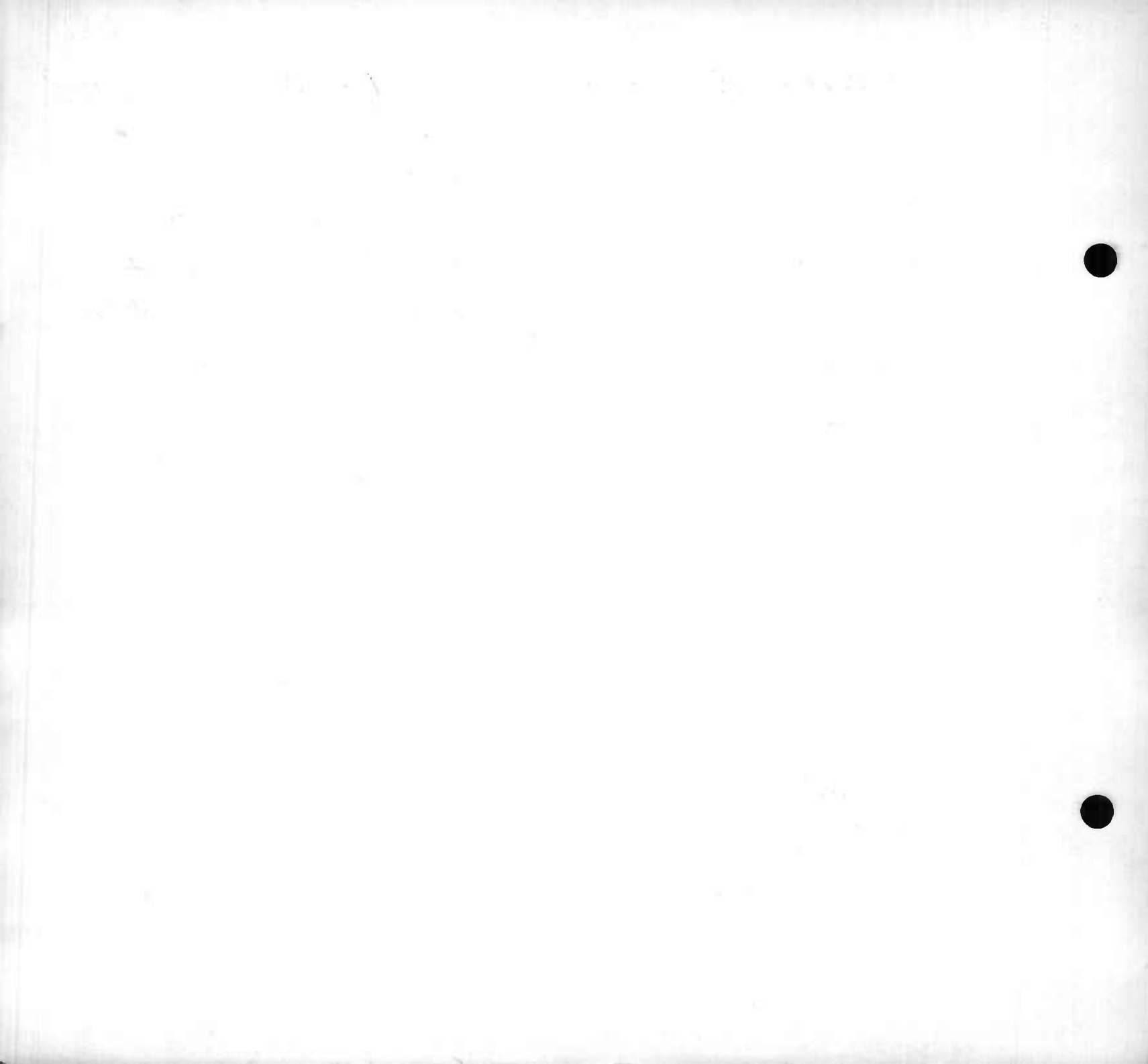
BALTIMORE CITY HEALTH DEPARTMENT		69 00546	
CERTIFICATE OF DEATH		REG. NO. 69 00546	
BIRTH NO. 69-00482		1. NAME OF DECEASED (Type or Print) <i>Baby Gail Williams</i>	
2. DATE AND HOUR OF DEATH <i>5:15 pm JAN 17 1969</i>		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <i>38 University Hospital Balto. Md 21201</i>		A. STATE <i>md</i> B. COUNTY <i>Howard Co. 63-00</i>	
5. SEX <i>F</i> 6. RACE <i>N</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <i>Lanval</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
8. DATE OF BIRTH <i>JAN 7 69</i> 9. AGE (in years last birthday) <i>0</i>		E. STREET AND NUMBER <i>Box 174 C</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <i>BALTO. md</i>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Unknown (According to our Records. W.M.K.)</i>		14. MOTHER'S MAIDEN NAME <i>Uwana</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>K Koskinen MD</i>		ADDRESS	
18. <i>742 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <i>multiple congenital anomalies including hydrocephalus</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>hydrocephalus</i> DUE TO, OR AS A CONSEQUENCE OF: (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes) or No <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>7 Jan 19 69</i> to <i>7 Jan 19 69</i> that (II) (we) last saw the deceased alive on <i>7 Jan 19 69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Kenneth Koskinen MD</i>		23B. DATE SIGNED <i>7 Jan 69</i>	
23C. PHYSICIAN'S NAME (Type) <i>KENNETH KOSKINEN</i>		23D. ADDRESS <i>University Hosp Balto md</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>1/15/69</i>		24B. DATE	
24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) <i>UNIVERSITY MEDICAL SCHOOL</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 16 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, MD</i>	
25C. FUNERAL DIRECTOR		25D. HOSPITAL DISPOSAL	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>68-23091</u>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>69 00547</u>	
1. NAME OF DECEASED (Type or Print) <u>MULLINS ALFRED</u>		2. DATE AND HOUR OF DEATH <u>1/4/69</u> (1969) <u>6:00 P.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Hannock</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIV. OF MD. HOSPITAL</u>		C. CITY OR TOWN <u>ELLICOTT CITY</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>		6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>11/23/68</u>		9. AGE (in years last birthday) <u>1</u>		10. If Under 1 Yr. Months <u>1</u> Days <u>12</u> Hours <u>12</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>HOWARD MULLINS</u>			
14. MOTHER'S MAIDEN NAME <u>BEVERLY WINNINGHAM</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. <u>569.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>NECROTIC BOWELS</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>SCHEMIA</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>0</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1/23</u> 19 <u>68</u> to <u>1/4</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>1/4</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John J. Spitznagel M.D.</u>		23B. DATE SIGNED <u>1/7/69</u>		23C. PHYSICIAN'S NAME (Type)	
23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify)			
24B. DATE <u>1/15/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>ANATOMY BOARD OF MARYLAND</u>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 16 1969</u>		25B. NAME OF REGISTRAR <u>D. B. E. J. J. J.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>HOSPITAL DISPOSAL</u>	

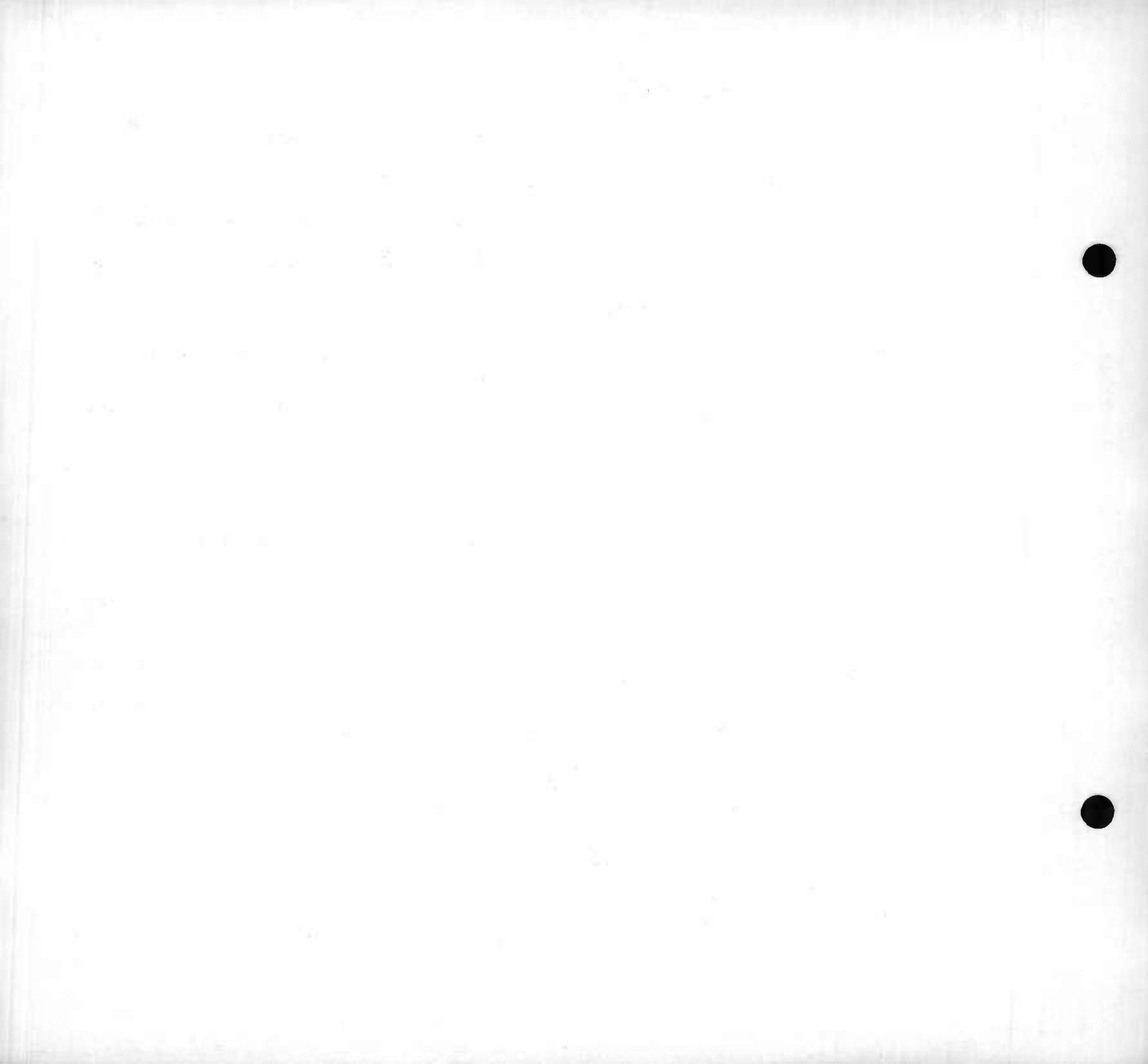




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 00548</u>
BIRTH NO. <u>69-00586</u>		69 00548 <b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <u>Baby Gine Tyndall</u>		2. DATE AND HOUR OF DEATH <u>1-10-69</u> <u>3<sup>26</sup></u> A.M.		
3. PLACE IN <u>BALTIMORE, MARYLAND</u> , WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>BALTIMORE</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY of Maryland Hospital</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>4 SOUTH CARRY STREET</u>		
5. SEX <u>Female</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-9-69</u>	9. AGE (In years last birthday) <u>—</u> Months <u>—</u> Days <u>—</u> Hours <u>14</u> Mins. <u>53</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>MILTON WELCH</u>		
14. MOTHER'S MAIDEN NAME <u>LULA MAC TYNDALL</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> <u>Newborn</u>		
16. SOCIAL SECURITY NO. <u>Newborn</u>		17. INFORMANT <u>GARY A. FLEMING, Univ. of Md. Hospital</u>		
18. <u>776.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>PREMATURITY</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>14 hours 53 min</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>14 hours 53 min</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) <u>Hyaline membrane disease</u> (C) <u>—</u>				
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>N/A</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N/A</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>N/A</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>N/A</u>
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>N/A</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>N/A</u>
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>1-9</u> 19 <u>69</u> to <u>1-10</u> 19 <u>69</u> that (I) <u>(we)</u> last saw the deceased alive on <u>1-10</u> 19 <u>69</u> and that (in my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death.				
23A. SIGNATURE <u>Gary A. Fleming, M.D.</u>				23B. DATE SIGNED <u>1-10-69</u>
23C. PHYSICIAN'S NAME (Type) <u>GARY A. FLEMING, M.D.</u>		23D. ADDRESS <u>UNIVERSITY of Maryland Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>11/5/69</u>		24B. DATE <u>11/5/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>ANATOMY BOARD OF MARYLAND</u>
24D. LOCATION (City, town, or county) (State) <u>UNIVERSITY MEDICAL SCHOOL</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 16 1969</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>HOSPITAL DISPOSAL</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 69 00549

BIRTH NO. 64-00096 69 00549

1. NAME OF DECEASED  
(Type or Print)

WILLIAMS, BABY GIRL

2. DATE AND HOUR OF DEATH

1-2-69 4:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

38 UNIV OF MARYLAND  
HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

MD. BALT. CITY 16-01

C. CITY OR TOWN

BALT.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

1110 HARLEM AVE. #17

5. SEX

F

6. RACE

N

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

1/2/69

9. AGE (In years  
last birthday)

10. Under 1 Yr. Months Days 13 15

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

INFANT

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

CHARLES BROWN

14. MOTHER'S MAIDEN NAME

CASSANDRA WILLIAMS

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

ERIC M. FINE, MD. (see below)

18. 776.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

CARDIORESP. ARREST

DUE TO, OR AS A CONSEQUENCE OF:

(B)

PULMONARY IMMATURIT

DUE TO, OR AS A CONSEQUENCE OF:

(C)

LOW BIRTH WT. INFANT

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No) ☒

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY  
(APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (my) (this hospital) attended the deceased, from 1/2/69 to 1/2/69  
that (I) last saw the deceased alive on 1/2/69 and that (my) (our) applan death occurred on the date  
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Eric M. Fine MD.

Attending  
Phys. ☐

Med.  
Director ☐

Staff  
Phys. ☒

23B. DATE SIGNED

1/2/69

23C. PHYSICIAN'S  
NAME (Type)

ERIC M. FINE, MD.

23D. ADDRESS

UNIV. OF MARYLAND HOSPITAL

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

1/15/69

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 16 1969

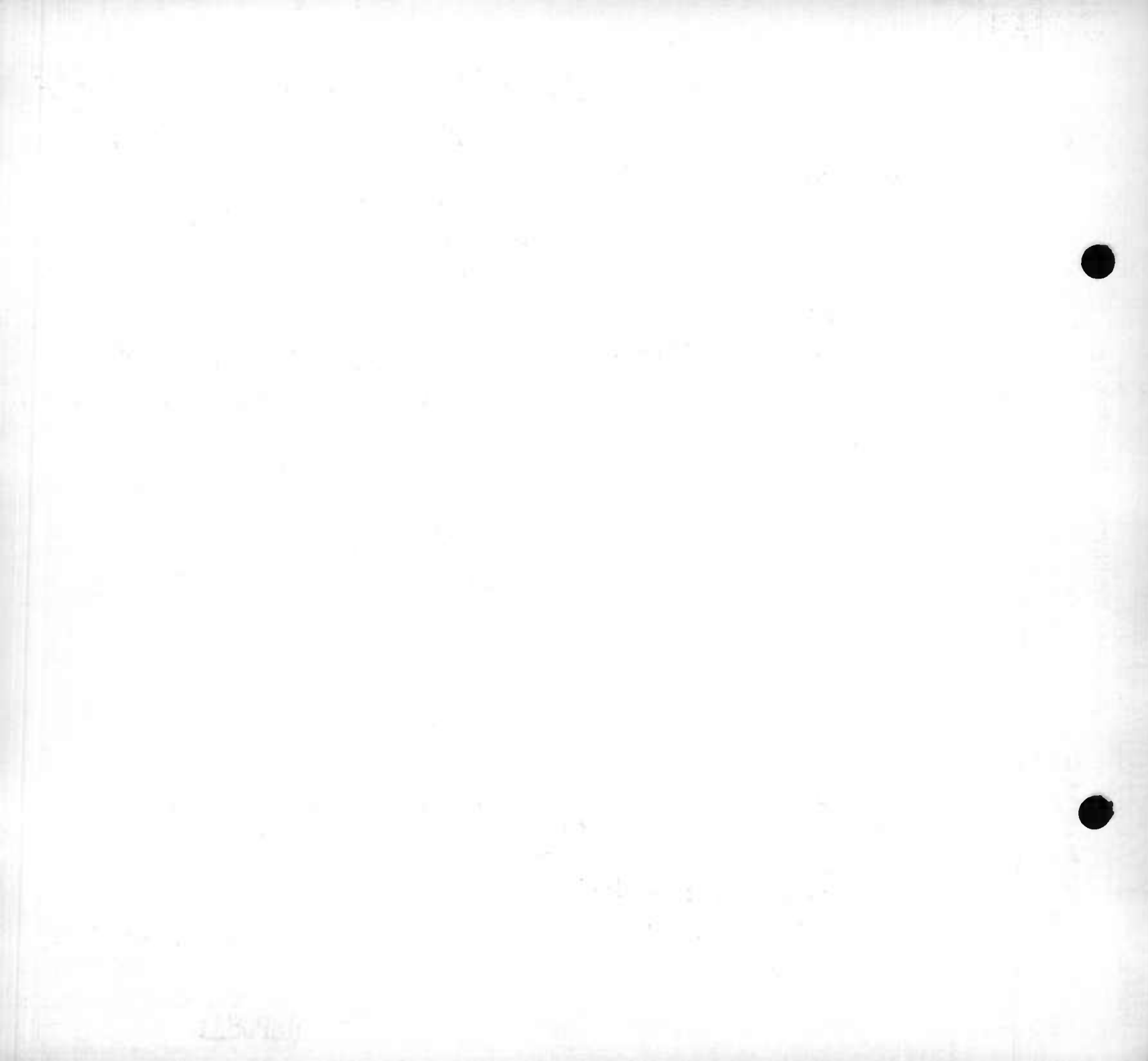
25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR

HOSPITAL DISPOSAL

ADDRESS



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

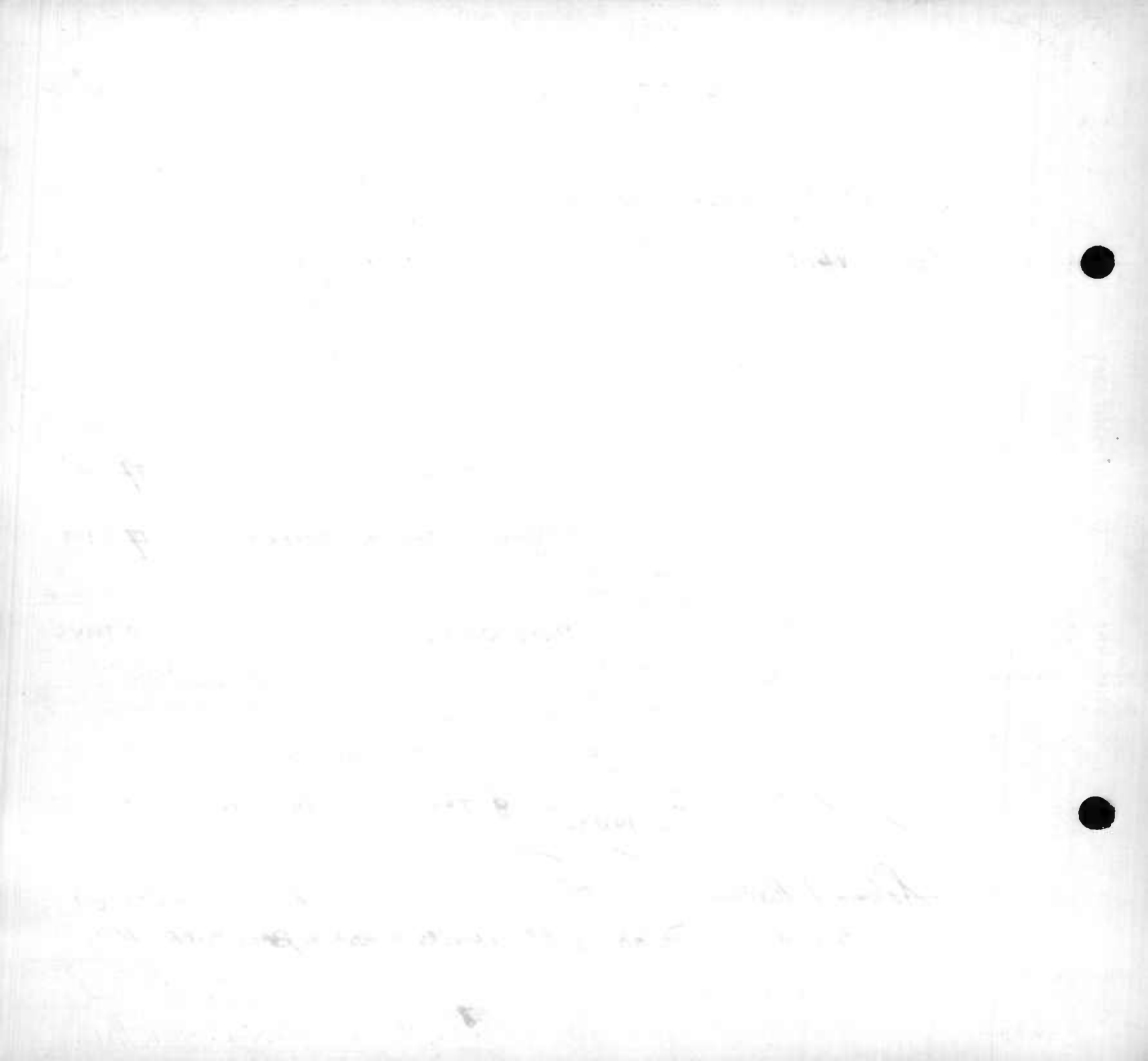
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>69 00550</u>	
BIRTH NO. <u>69 00550</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Taylor Anne M.</u>		2. DATE AND HOUR OF DEATH <u>Jan 15 '69</u> <u>2<sup>00</sup></u> P. M.	
3. PLACE OF DEATH IN <u>BALTIMORE, MARYLAND</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>27-38</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>The Union Memorial Hospital</u>		C. CITY OR TOWN <u>Baltimore</u>		D. STREET ADDRESS <u>6100 Marlora Rd.</u>	
5. SEX <u>Female</u>	6. RACE <u>white</u>	7. MARRIED, <del>NEVER MARRIED</del> WIDOWED, DIVORCED (specify) <u>Single</u>	8. DATE OF BIRTH <u>08-22-22</u>	9. AGE (In years lost birthday) <u>46</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>William C. Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Dulaney</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Chart. Union Mem. Hosp. Balt.</u>		ADDRESS	
18. <u>182.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Terminal carcinoma of uterus</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>June '68</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Metastatic Ca of uterus</u>					
19A. DATE OF OPERATION <u>0 July '68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <u>June 19 68</u> to <u>Jan 15 19 69</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>Jan 15 19 69</u> and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <u>we</u> ) ( <u>did</u> ) ( <u>did not</u> ) view the body after death.					
23A. SIGNATURE <u>John H. Hebb</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>1/15/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOHN H. HEBB</u>		23D. ADDRESS <u>8413 Loch Raven Blvd</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/18/69</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 16 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Salsbery</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT REG. NO. 69 00551			
BIRTH NO. 69 00551		<b>CERTIFICATE OF DEATH</b>	
1. NAME OF DECEASED (Type or Print) <b>RIESETT, EDNA MARIE</b>		2. DATE AND HOUR OF DEATH <b>14 JAN 1969 9:00 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY OF MARYLAND HOSPITAL</b> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1119 Scott St - 21230</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/16/1991</b> 9. AGE (In years last birthday) <b>77</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleslady</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Store</b>	
11. BIRTHPLACE (State or foreign country) <b>Balti. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Tractor Behrens</b>		14. MOTHER'S MAIDEN NAME <b>Mary -</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>Roland E. Riesett</b>		ADDRESS <b>2903 Glenmore Ave (21214)</b>	
18. <b>432.91</b> CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <b>BRAIN STEM INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) <b>THROMBOSIS BASILAR ARTERY</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>PNEUMONITIS</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>17 DAYS</b>  <b>17 DAYS</b>  <b>2 DAYS</b>	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>8 JAN 19 69</b> to <b>14 JAN 19 69</b> that (1) (we) last saw the deceased alive on <b>14 JAN 19 69</b> and that (1) (my) (my) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Solomon D Robbins</b>		23B. DATE SIGNED <b>14 JAN 69</b>	
23C. PHYSICIAN'S NAME (Type) <b>SOLOMON D. ROBBINS MD</b>		23D. ADDRESS <b>UNIVERSITY HOSPITAL, BALTIMORE MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/18/1969</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		24D. LOCATION (City, town, or county) (State) <b>Balti. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 16 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>	
25C. FUNERAL DIRECTOR <b>John J. Cowan, Sr. Inc.</b>		ADDRESS <b>901 Hallam St - 21223</b>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 00552	
69 00552				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>EDWARD MORSE</b>		2. DATE AND HOUR OF DEATH <b>JAN 14, 1969 1 799 A M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Harford</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 The Johns Hopkins Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Bel Air</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Superintendent</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Golf Course</b>		8. DATE OF BIRTH <b>9/1/17</b> 9. AGE (in years last birthday) <b>51</b>	
13. FATHER'S NAME <b>R. Everett Morse</b>		14. MOTHER'S MAIDEN NAME <b>Kathryn Strauss</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WW #2</b>		16. SOCIAL SECURITY NO. <b>218-10-8986</b>		17. INFORMANT (Wife 838-5730) <b>RD#2 Mrs. Anne S. Morse Bel Air, Maryland 21014</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>204.1 I pulmonary infarct</b>		CAUSE OF DEATH <b>UNKNOWN etiology</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Chronic lymphocytic leukemia</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>unknown</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <b>1/2</b> 19 <b>69</b> to <b>1/14</b> 19 <b>69</b> that (I) (we) last saw the deceased alive on <b>1/14</b> 19 <b>69</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>William W. Lukens Meyer M.D.</b>		23B. DATE SIGNED <b>1-14-69</b>		23C. PHYSICIAN'S NAME (Type) <b>WILLIAM W. LUKENS MEYER M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>JAN. 17, 1969</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 16 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>Joseph William Foster</b>	
24D. LOCATION (City, town, or county) (State) <b>Bel Air, Harford Co., Maryland 21014</b>		25D. ADDRESS <b>W. Broadway &amp; Williams St. Bel Air, Maryland 21014</b>			

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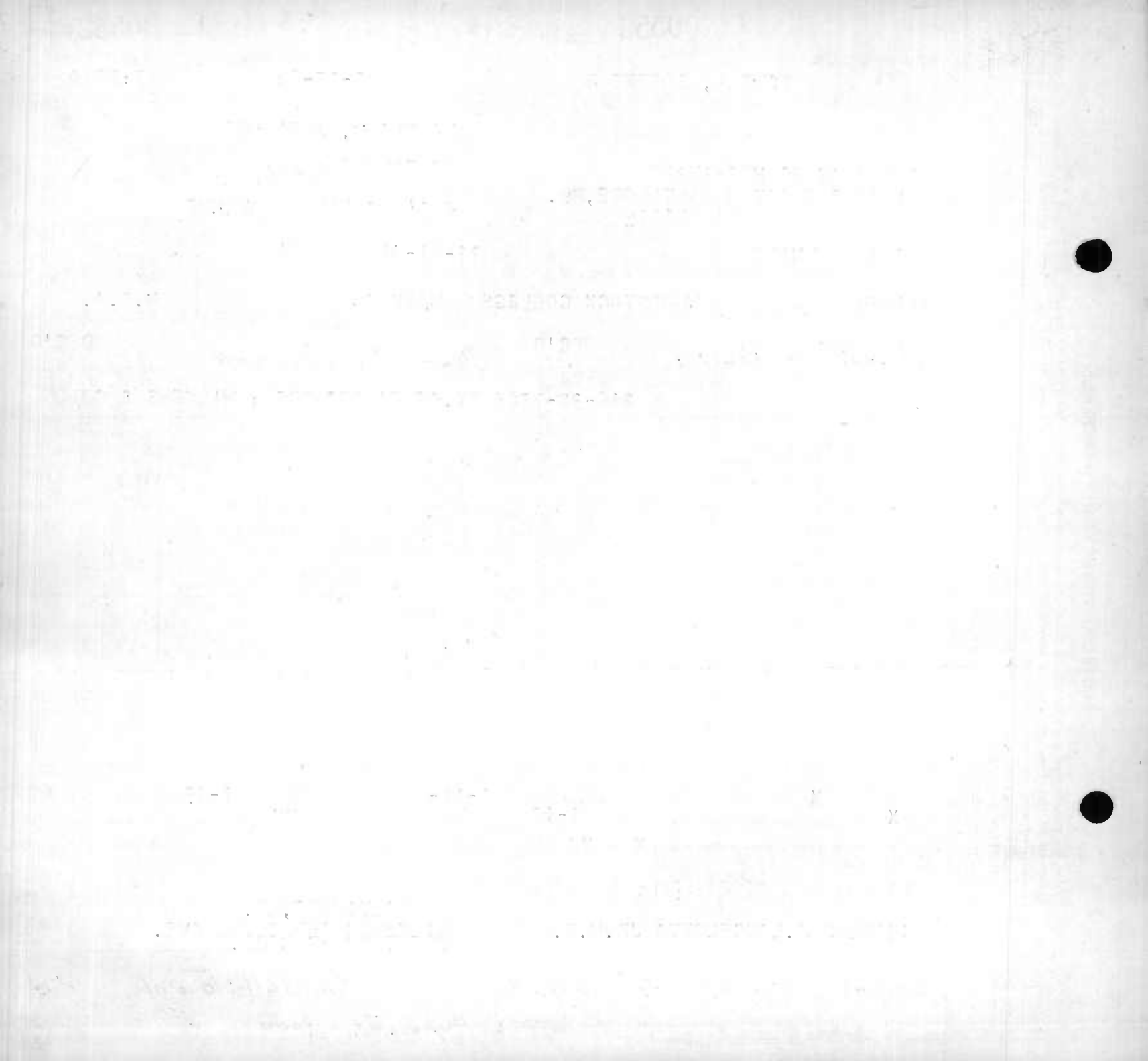
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
POWELL, ROBERT R				1-13-69		7:20 A	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
SAINT AGNES HOSPITAL WILKENS & CATON BALTIMORE, MD. 21229				MARYLAND, BALTIMORE 53-00			
5. SEX				6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
MALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
						11-01-04	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years lost birthday)	
RETIRED				WOODSTOCK COLLEGE		64	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Robert W. Powell				DORA M. Tilghman		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
NO				216-32-7305		ST. AGNES RECORDS ; WILKENS & CATON	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF:			
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 1-10-19 69 to 1-13-19 69, that (X) (we) last saw the deceased alive on 1-13-19 69 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (X) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
CHARLES J. LANCELOTTA JR. M.D.				1/13/69			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
CHARLES J. LANCELOTTA JR. M.D.				BALTIMORE, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial				1-16-69		MT Olive	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 16 1969				Robert E. Jackson		Higginbotham Slaw	
24D. LOCATION (City, town, or county)				24E. LOCATION (State)			
Randalls Town				MD.			
24F. ADDRESS				24G. ADDRESS			
Elliot City, Md.							



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69 00554 BALTIMORE CITY HEALTH DEPARTMENT

69 00554

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>R. RICHARD HOLLAND</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <b>1</b> Day <b>12</b> Year <b>69</b> Hour <b>8:50 p.m.</b> Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>48 99 Maryland General Hospital D.O.A.</b>		3. DATE PRONOUNCED DEAD Month <b>January</b> Day <b>12</b> Year <b>1969</b> Hour <b>8:50 p.m.</b>	
6. SEX <b>Male</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE <b>White</b>		C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>9/7/1918</b>		10. AGE (In years lost birthday) <b>50</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accounting</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>A. A. A. Club</b>	
15. MOTHER'S MAIDEN NAME <b>Anna Brennan</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>	
17. SOCIAL SECURITY NO. <b>212-07-8274</b>		18. INFORMANT <b>Catherine L. Delaro, sister</b> ADDRESS <b>3408 Elmley Ave. 21213</b>	
19. <b>412.21</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(B)</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(C)</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) <b>YES</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Edward F. Wilson</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>1/13/69</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/16/69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 16 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>	
25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc 3331 Brehms Lane</b>			

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

63 00555

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>Edward CHARLES E. SMITH JR.</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year <b>January 11, 1969</b>		Hour <b>1:00 P.</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>January 11, 1969</b>		Hour <b>1:00 P.</b>
6. SEX <b>Male</b>		7. RACE <b>White</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH <b>6/14/94</b>		10. AGE (In years last birthday) <b>74</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>Charles E. Smith</b>		13. FATHER'S NAME <b>Charles E. Smith</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tavern</b>
15. MOTHER'S MAIDEN NAME <b>Susan Howard</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes W W 2 - Army 213-28-8489</b>		17. SOCIAL SECURITY NO. <b>Margaret Lewis Smith, wife, above</b>
18. INFORMANT <b>Margaret Lewis Smith, wife, above</b>		19. CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		22. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b>		23. (B) DUE TO, OR AS A CONSEQUENCE OF: (C)
24. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>11</b>		25. DATE OF OPERATION <b>1/15/69</b>		26. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>1/15/69</b>
27. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <b>22A. DATE OF OPERATION</b>		28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>22B. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?</b>		29. AUTOPSY? (Yes or No) <b>No</b>
30. TIME OF INJURY (APPROX.) <b>22D. TIME (Month) (Day) (Year) (Hour)</b>		31. INJURY OCCURRED <b>22E. INJURY OCCURRED</b>		32. HOW DID INJURY OCCUR? <b>22F. HOW DID INJURY OCCUR?</b>
33. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		34. CHIEF MEDICAL EXAMINER <b>Charles S. Springate, M.D.</b>		35. DATE SIGNED <b>January 12, 1969</b>
36. ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b>		37. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		38. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
39. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		40. DATE <b>1/15/69</b>		41. NAME OF CEMETERY or CREMATORY <b>Holly Hill Mem. Gardens</b>
42. DATE REC'D BY HEALTH DEPT. <b>JAN 16 1969</b>		43. NAME OF REGISTRAR <b>Robert E. Schumnek</b>		44. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>
45. ADDRESS <b>2601 E. Madison St.</b>		46. ADDRESS <b>2601 E. Madison St.</b>		47. ADDRESS <b>2601 E. Madison St.</b>

WALKER



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>HEBRON, AMANDA</b>				2. DATE AND HOUR OF DEATH <b>11/12/69 8<sup>30</sup> A.M.</b>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>18-02</b>							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>38 UNIVERSITY OF MARYLAND HOSP REDWOOD &amp; GREENE ST BALTO. MD. 21201</b>				C. CITY OR TOWN <b>BALTIMORE</b>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <b>1029 SARAH ANN ST.</b>											
5. SEX <b>F</b>		6. RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/90</b>		9. AGE (In years lost birthday) <b>78</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO.				17. INFORMANT <b>Spring Grove Hospital</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease or complication which caused death.) <b>GANGRENE (STREPTOCOCCAL)</b>				CAUSE OF DEATH <b>GANGRENE (STREPTOCOCCAL)</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, given rise to the above cause (A) stating UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Head Injury</b>				(B) <b>Fracture of Lower Lip</b> DUE TO, OR AS A CONSEQUENCE OF: <b>6 days</b>			
(C) <b>BLUNT IMPACT TO FACE</b>											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION <b>2-</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <b>Hospital</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Spring Grove 53-00</b>							
21D. TIME OF INJURY (APPROX.) <b>1/2/68 10AM</b>		21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>granted chair fell</b>							
22. I certify that (I) (this hospital) attended the deceased from <b>1/5</b> 19 <b>69</b> to <b>1/12</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>1/11</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>A. W. and</b>				23B. DATE SIGNED <b>11/12/69</b>							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-15-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>BACONTOWN Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>LAUREL Prince Geo. Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 16 1969</b>		25B. NAME OF REGISTRAR <b>George R. Snowden</b>		25C. FUNERAL DIRECTOR <b>Rockwell</b>		ADDRESS					



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67 00557 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 00557

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JOSEPH NEALE Jr.</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>January 11, 1969 12:55 P.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>33 Johns Hopkins Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 11, 1969 12:55 P.M.</b>	
5. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>66-00 Prince George</b>		C. CITY OR TOWN <b>Aquasco</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>10-2-1947</b>		10. AGE (In years last birthday) <b>21</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph J. Neale, Senior</b>		14. MOTHER'S MAIDEN NAME <b>Jane U. Savoy</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 1965-1967</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Father</b>		ADDRESS <b>Same</b>	
19. CAUSE OF DEATH <b>E.P.I.S.D. I</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Cerebro-cranial injuries</b> DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>highway</b>	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? <b>St. Rte. 381 approximately 500' N. of Pr. Frederick - Charles Co. line</b>		22F. HOW DID INJURY OCCUR? <b>Driver in auto-fixed object collision</b>	
22D. TIME OF INJURY (APPROX.) <b>1-11-69 2:00 A.M.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>January 12, 1969</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-15-69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Resurrection Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Clinton - Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 16 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Martell Adams</b>		ADDRESS <b>Aquasco, Md.</b>	

VALLEY

COPIES

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67 00558

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

67 00558

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>MARY JANE REED</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>January 11, 1969</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>810 Newington Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 11, 1969 7:35 P. M.</b>	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH 10. AGE (In years last birthday) <b>100</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		E. STREET AND NUMBER <b>810 Newington Avenue</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Mrs. Annie Dollar</b>	
19. <b>412.4</b>		ADDRESS <b>810 Newington Ave</b>	
CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>No</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>January 12, 1969</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>1-14-69</b>	
24C. NAME of CEMETERY or CREMATORY <b>Manning Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Valentine, Virginia</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR <b>Dan Brown Funeral Home</b>		ADDRESS <b>Lawrence Va.</b>	

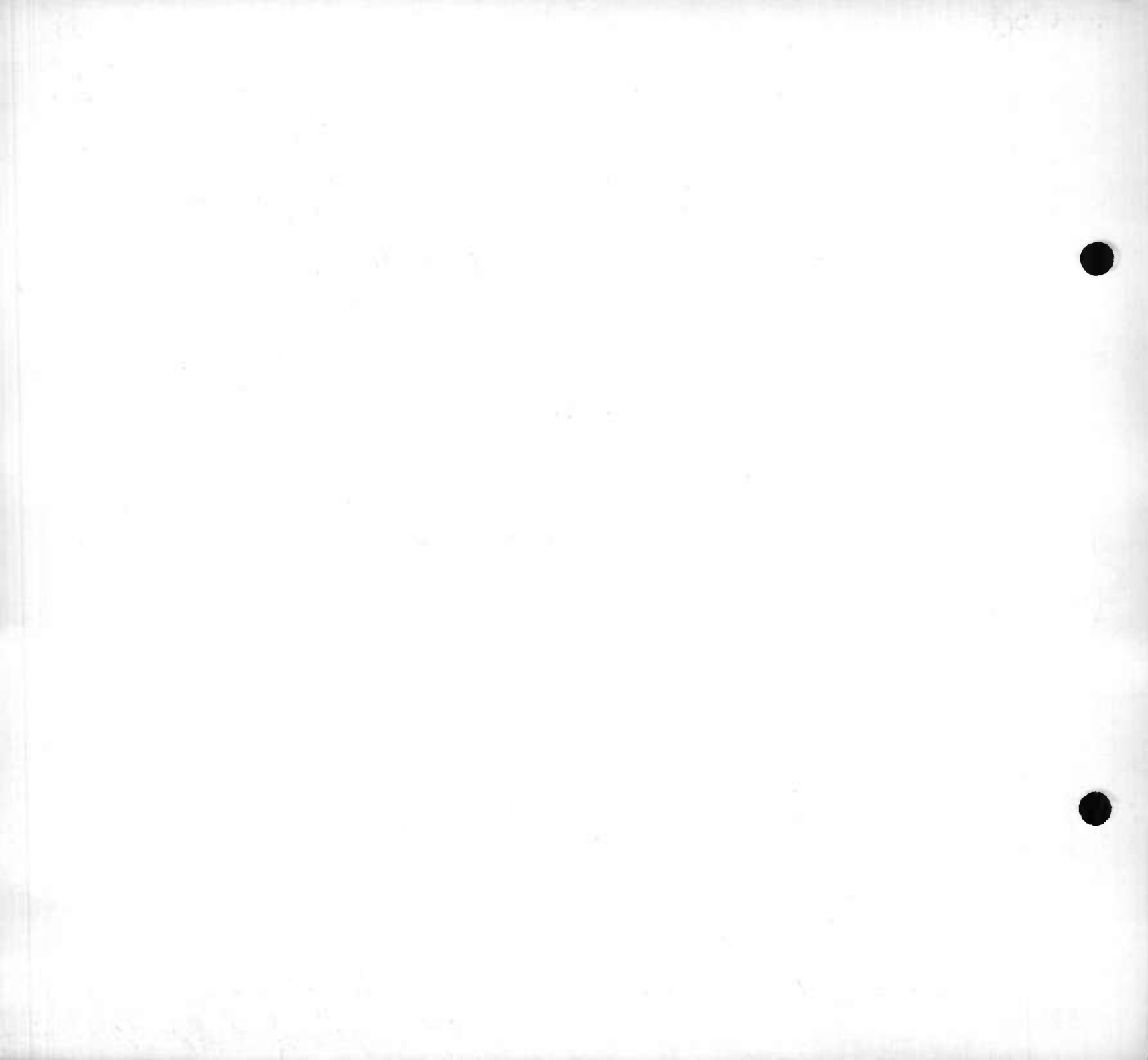
WALTERS & PORGES

WALTERS & PORGES

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67 00559 CERTIFICATE OF DEATH				REG. NO. 67 00559			
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Hill, A. Fannie</i>				2. DATE AND HOUR OF DEATH <i>Jan. 10, 1969 9:20 PM</i> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>15-02</i>							
FULL NAME OF HOSPITAL OR INSTITUTION <i>38 University Hospital</i>				C. CITY OR TOWN <i>Baltimore</i>				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER <i>1827 N. Affleton St.</i>							
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-1-16</i>		9. AGE (in years last birthday) <i>52</i>		10. Under 1 Yr. Months: Days: Hours: Min.		11. Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <i>James Atkins</i>				14. MOTHER'S MAIDEN NAME <i>Jannie Goode</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>214-24-1489</i>				17. INFORMANT <i>Thaddeus Hill</i> ADDRESS <i>Same</i>			
18. <i>183.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <i>① Uremia</i> DUE TO, OR AS A CONSEQUENCE OF: <i>② Carcinoma of peritoneum</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 yrs</i>			
(B) <i>C. of Colon</i> DUE TO, OR AS A CONSEQUENCE OF:				(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>History of C. of ovary (1957). C. of Colon (1964)</i>											
19A. DATE OF OPERATION <i>7-10-69</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?				22. I certify that (I) (this hospital) attended the deceased from <i>July 10, at 6:30 PM</i> 19 <i>69</i> to <i>Jan 10, 9:20 PM</i> 19 <i>69</i> that (I) (we) lost saw the deceased alive on <i>July 10, at 9:30 PM</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <i>(I) (We) (did)</i> (did not) view the body after death.							
23A. SIGNATURE <i>Shao-Huang Chieh, M.D.</i>				23B. DATE SIGNED <i>1 -</i>				23C. PHYSICIAN'S NAME (Type) <i>Shao-Huang Chieh, M.D.</i>			
23D. ADDRESS <i>Univ. of Maryland Hospital</i>				24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>1-15-69</i>			
24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Mem. St.</i>				24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>				25A. DATE REC'D BY HEALTH DEPT. <i>JAN 16 1969</i>			
25B. NAME OF REGISTRAR <i>R. E. E. Jones</i>				25C. FUNERAL DIRECTOR <i>Wilmington, Del.</i>				25D. ADDRESS <i>Wilmington, Del.</i>			

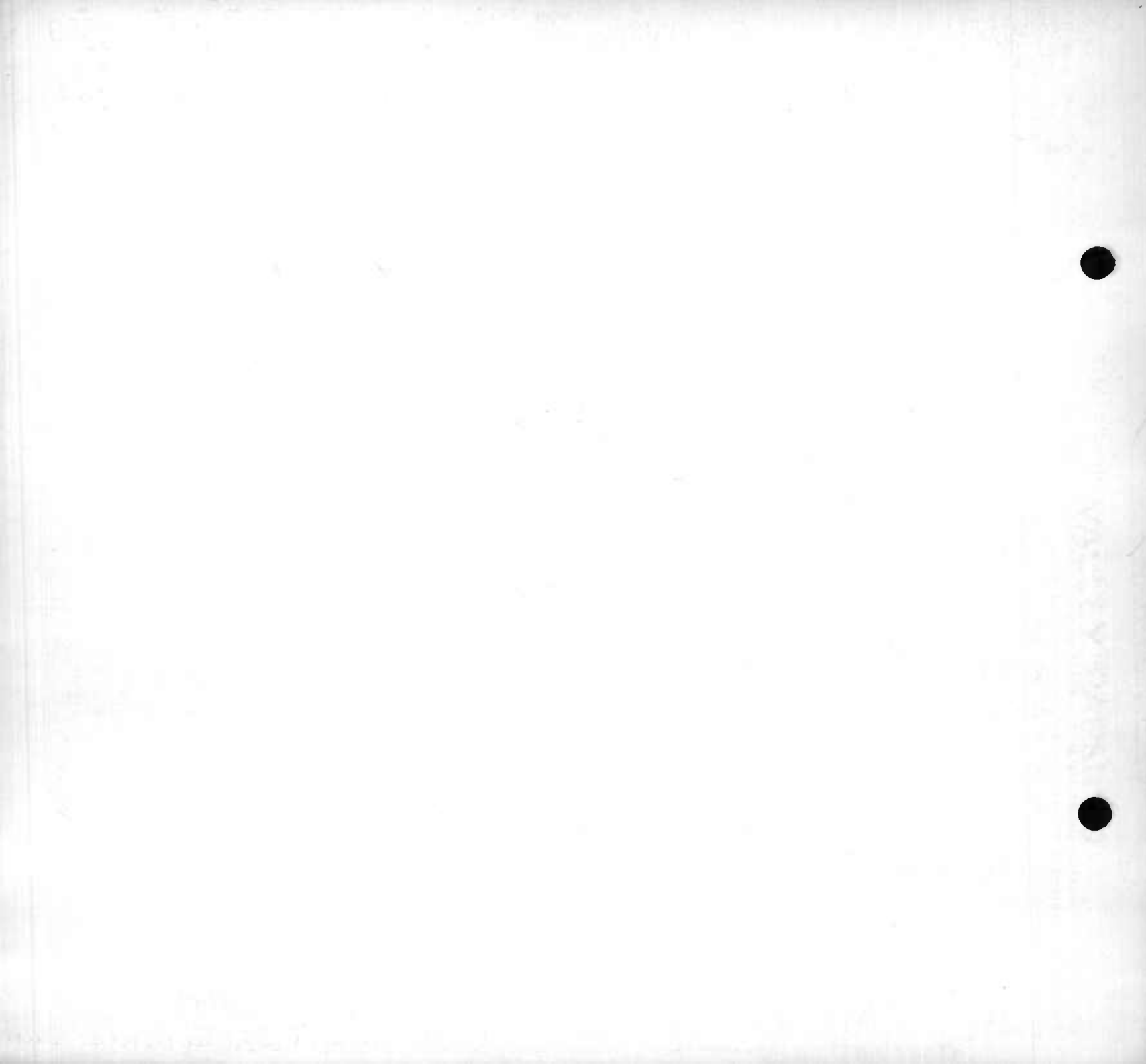




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
69 00560 CERTIFICATE OF DEATH											
REG. NO. 69 00560											
BIRTH NO. 69 00560											
1. NAME OF DECEASED (Type or Print) <u>WILLIE DARDEN</u>											
2. DATE AND HOUR OF DEATH <u>1-16-69</u> <u>11:54</u> <u>PM</u>											
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIVERSITY HOSPITAL</u>						A. STATE <u>MD.</u> B. COUNTY <u>16-06</u>					
C. CITY OR TOWN <u>BALTIMORE</u>						D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
E. STREET AND NUMBER <u>2644 EDMONDSON AVE</u>											
5. SEX <u>MALE</u>		6. RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/18/04</u>		9. AGE (In years last birthday) <u>64</u>		10. If Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>HENRY DARDEN</u>				14. MOTHER'S MAIDEN NAME <u>ELLEN STREETER</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>239-20-4963</u>				17. INFORMANT <u>CHART WIFE</u> ADDRESS <u>2644 EDMONDSON AVE</u>			
18. CAUSE OF DEATH											
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH											
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)											
ANTECEDENT CAUSES											
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
(A) IMMEDIATE CAUSE <u>METABOLIC ACIDOSIS</u> DUE TO, OR AS A CONSEQUENCE OF: <u>8 hrs.</u>											
(B) <u>RENAL FAILURE &amp; DEHYDRATION 2 Days</u> DUE TO, OR AS A CONSEQUENCE OF: <u>?</u>											
(C) <u>CHRONIC &amp; ACUTE RENAL DISEASE</u>											
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>SINUSITIS</u>											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>50 days</u>											
MEDICAL CERTIFICATION											
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At <input type="checkbox"/> Work At <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>1/13</u> 19 <u>69</u> to <u>1/16</u> 19 <u>69</u> that (I) ( <u>we</u> ) last saw the deceased alive on <u>1/16</u> 19 <u>69</u> and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <u>we</u> ) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Andrew Jay Vola M.D.</u> DEGREE								23B. DATE SIGNED <u>1/16/69</u>		23C. PHYSICIAN'S NAME (Type)	
23D. ADDRESS											
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>											
24B. DATE <u>1-20-69</u>											
24C. NAME OF CEMETERY OR CREMATORY <u>Wm. Calvary</u>											
24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>											
25A. DATE RECEIVED BY HEALTH DEPT. <u>JAN 17 1969</u>											
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>											
25C. FUNERAL DIRECTOR <u>C. Wainwright</u> ADDRESS <u>2700 Edmondson Ave.</u>											



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0561

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 0561

BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Violet M. Milburn</b>		1-12-69 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>46 Lutheran Hospital</b>		A. STATE <b>Md.</b> B. COUNTY <b>15-38</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>2500 Easinor Ave.</b>	
5. SEX <b>Female</b>	6. RACE <b>Negroid</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-10-00</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) <b>68</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
		17. INFORMANT ADDRESS <b>Evelyn Press 313 Edgewood Street</b>	
18. <b>436.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Cerebral accident</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Arterio sclerosis</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b> <b>15 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>9-13-1968</b> to <b>1-13-1969</b> , that (I) (we) last saw the deceased alive on <b>1-6-1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>John E. T. Camper, M.D.</b>		23B. DATE SIGNED <b>1-16-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOHN E. T. CAMPER, M.D.</b>		23D. ADDRESS <b>639 N. Carey St. Baltimore Maryland</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-16-69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. Park</b>		24D. LOCATION <b>Arbutus Maryland</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>JAN 17 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>Nelson F.H.</b>		ADDRESS <b>1348 N. Calhoun Street</b>	



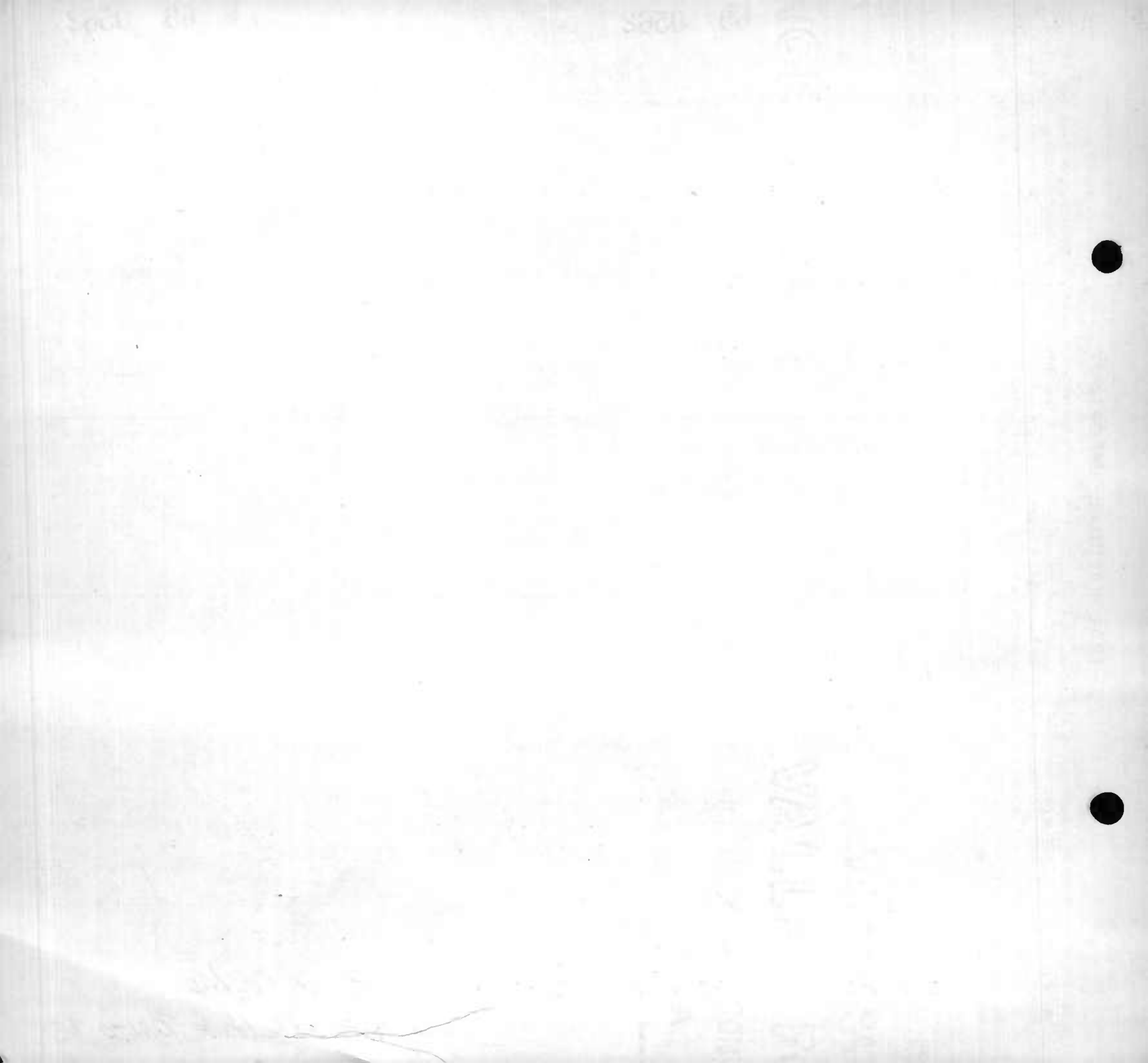
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0562 BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 0562

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Alberta C. Ulrich</b>		2. DATE AND HOUR OF DEATH <b>1/14/69 12:15 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Balt.</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>48 Maryland General</b>			C. CITY OR TOWN <b>Balt</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>2876 Pelham Ave</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/3/06</b>	9. AGE (In years last birthday) <b>62</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>William Wheary</b>		
14. MOTHER'S MAIDEN NAME <b>Christina Schweit</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>213 32 4069</b>			17. INFORMANT <b>patient</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Carcinoma or Breast</b> <b>&amp; Pulmonary metastases</b>					
(B) DUE TO, OR AS A CONSEQUENCE OF: 					
(C) DUE TO, OR AS A CONSEQUENCE OF: 					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>1/12/69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cox Breast</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/28 1968</b> to <b>1/14 1969</b> , that (I) (we) last saw the deceased alive on <b>1/14 1969</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. W. Faulk M.D.</b>				23B. DATE SIGNED <b>1/14/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>J. W. Faulk</b>				23D. ADDRESS <b>Maryland General</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-17-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>PARKWOOD CEM.</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO. CO., MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1969</b>			
25B. NAME OF REGISTRAR <b>Robert E. Faulk</b>		25C. FUNERAL DIRECTOR <b>ULRICH FUNERAL HOME, BALTO., MD.</b>			
25D. ADDRESS					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

69 0563

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

William H. Simpson

2. DATE AND HOUR OF DEATH

1/13/69

7:45 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

4404 Raspe Ave.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

4404 Raspe Ave.

5. SEX

Male

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☒

8. DATE OF BIRTH

11/26/84

9. AGE (In years lost birthday)

84

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William H. Simpson

14. MOTHER'S MAIDEN NAME

Matilda Reynolds

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

215-10-1920

17. INFORMANT

ADDRESS

Martha C. Wright - 4404 Raspe Ave.

18. 410.9 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Arteriosclerotic Heart Disease

ASHD

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 Mo.

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Dec. 11 1968 to Jan. 13 1969, that (I) (~~we~~) last saw the deceased alive on Jan. 10 1969 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~we~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S NAME (Type)

Dr. Stephen Toms

Attending Phys. ☒Med. Director ☐Staff Phys. ☐

23B. DATE SIGNED

1/15/69

23D. ADDRESS

1712 Winford Rd. - Balto., Md. 21214

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1/16/69

24C. NAME OF CEMETERY or CREMATORY

Loudon Park Cemetery

24D. LOCATION

Baltimore

(City, town, or county)

(State)

Maryland

25A. DATE REC'D BY HEALTH DEPT.

JAN 17 1969

25B. NAME OF REGISTRAR

Robert E. Fisher

25C. FUNERAL DIRECTOR

Robert C. Altenburg Funeral Home, Inc. 6009 Harford Rd. - Balto., Md. 21214

ADDRESS

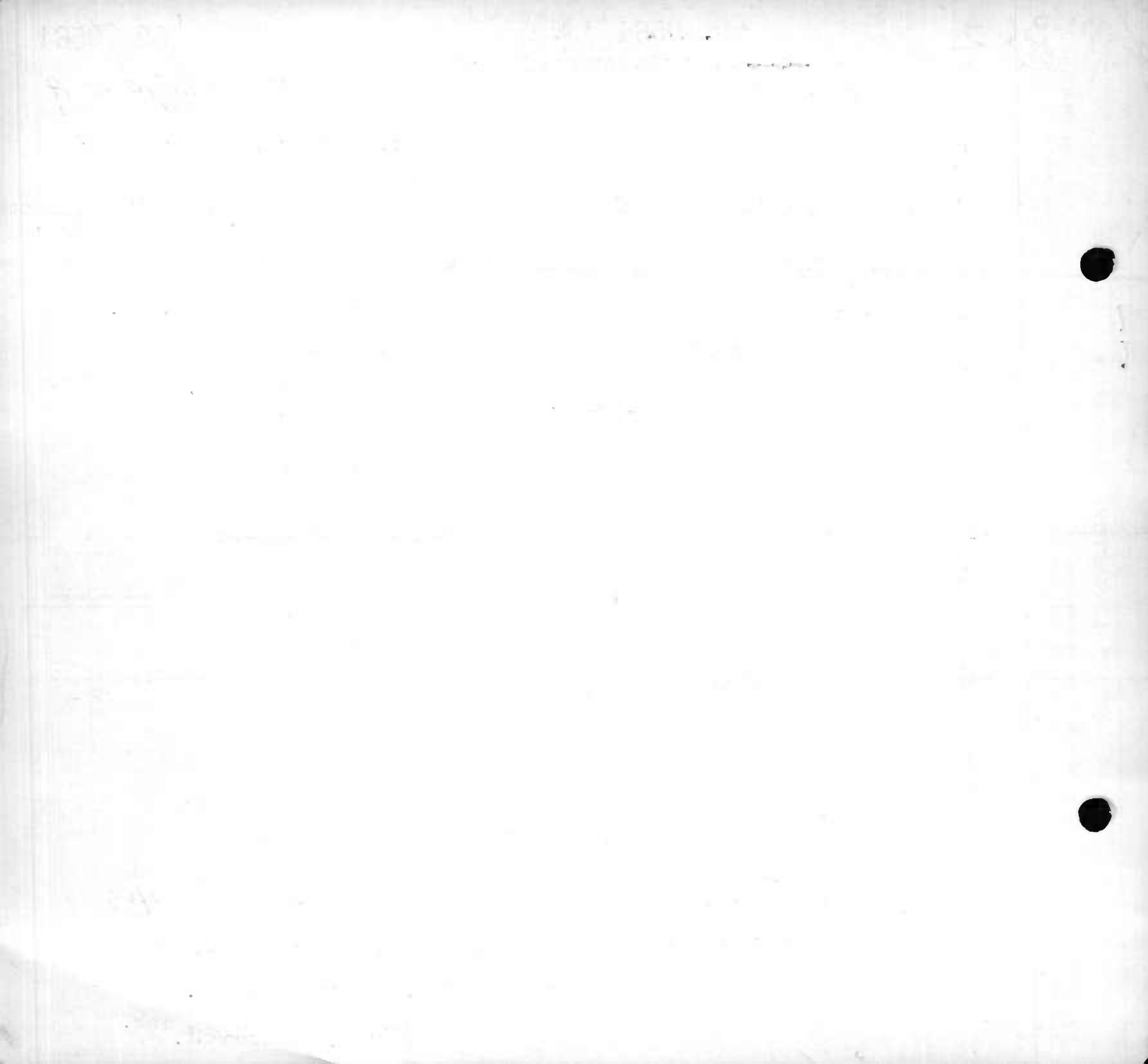




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69. 0564		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 0564	
1. NAME OF DECEASED (Type or Print) <i>Matras, Carla (Carrie) KARla</i>		2. DATE AND HOUR OF DEATH <i>1/14/68 10:45 A M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <i>33 The Johns Hopkins Hospital</i>		<i>Maryland, Baltimore 27-33</i>			
5. SEX <i>Female</i>		6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		8. DATE OF BIRTH <i>11/23/85</i>	
13. FATHER'S NAME <i>Kral</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>		9. AGE (In years last birthday) <i>83</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>213-07-8716D</i>		11. BIRTHPLACE (State or foreign country) <i>Czechoslovakia</i>	
17. INFORMANT <i>4219 Overton Ave. Frances Matthews, neice</i>		ADDRESS <i>21236</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Aspiration pneumonia</i>		<i>12 hrs</i>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>hip fracture, pulmonary embolus, Acute GI bleed, Gangrene</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION <i>3/12/9/68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Sub Capital Fx. L. Hip</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>N.A.</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>Harford gardens N.A. 27-33</i>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <i>12/6/68 6:30 PM</i>		21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>got up from chair &amp; tried to walk unaided</i>	
22. I certify that (A) (this hospital) attended the deceased from <i>12/6</i> 19 <i>68</i> to <i>1/14</i> 19 <i>69</i> that (B) (we) last saw the deceased alive on <i>1/14/69</i> and that (C) (my) (our) opinion death occurred on the date and hour and from the causes stated above (D) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>David A. Bass</i>		23B. DATE SIGNED <i>1/14/69</i>		23C. PHYSICIAN'S NAME (Type) <i>DAVID A. BASS</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/17/69</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Bohemian National Cem.</i>	
24D. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		25A. DATE RECEIVED BY HEALTH DEPT. <i>JAN 17 1969</i>		25B. NAME OF REGISTRAR <i>John E. Tarkenton</i>	
25C. FUNERAL DIRECTOR <i>Schimunek Funeral Home, Inc.</i>		25D. ADDRESS <i>2601 E. Madison St.</i>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>GEORGE FRANK</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <b>1</b> Day <b>13</b> Year <b>69</b> Hour <b>5:30 a.m.</b> Estimated <input type="checkbox"/>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>33 Johns Hopkins Hospital D.O.A.</b>				3. DATE PRONOUNCED DEAD Month <b>January</b> Day <b>13</b> Year <b>1969</b> Hour <b>5:30 a.m.</b>			
6. SEX <b>Male</b>				7. RACE <b>White</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>4/16/1906</b>				10. AGE (In years lost birthday) <b>62</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <b>John Frank</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inspector</b>	
15. MOTHER'S MAIDEN NAME <b>unknown</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO. <b>213-10-4701</b>	
18. INFORMANT <b>Catherine Quinn Frank, wife, above</b>				19. CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>		20. DATE OF OPERATION <b>4-12-69</b>	
21. AUTOPSY? (Yes or No) <b>Partial</b>				22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		23. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
24. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.				25. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		26. HOW DID INJURY OCCUR?	
27. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> P Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				28. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		29. DATE SIGNED <b>1/13/69</b>	
30. ACTUAL SIGNATURE <b>Edward F. Wilson, M.D.</b>				31. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		32. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
33. 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				34. 24B. DATE <b>1/17/69</b>		35. 24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cem.</b>	
36. 24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>				37. 25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1969</b>		38. 25B. NAME OF REGISTRAR <b>Edmund J. Faldut</b>	
39. 25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>				40. ADDRESS <b>3331 Brehms Lane</b>		41. 25D. DATE <b>1/17/69</b>	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0566

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

69 0566

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WEIDNER, Miss. GRACE E.

2. DATE AND HOUR OF DEATH

Jan. 14 - 1969

1 05 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

BON SECOURS Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

21228

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

419 Overbrook Rd.

5. SEX

F

6. RACE

W

7. MARRIED ☐NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

6/2/01

9. AGE (In years  
last birthday)

67

If Under 1 Yr.

Months

If Under 24 Hrs.

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housework

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Baltimore  
Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

William A. Weidner

14. MOTHER'S MAIDEN NAME

ANNIE BOULDIN

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Helen Weidner, sister, above

18.

150X I  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Ca of esophagus?

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ☒ (this hospital) attended the deceased from Jan 1 - 1969 to Jan 14 1969,  
that ☒ (we) last saw the deceased alive on Jan 14 1969 and that in ☒ (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. ☒ (We) (did) (did not) view the body after death.

23A. SIGNATURE

M. Sarkarati - M.D.

DEGREE

Attending ☐  
Phys.Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

Jan. 14 - 1969

23C. PHYSICIAN'S  
NAME (Type)

Mehdi Sarkarati, M.D.

DEGREE

23D. ADDRESS

Bon Secours Hospital

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1/17/69

24C. NAME OF CEMETERY or CREMATORY

Parkwood Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 17 1969

25B. NAME OF REGISTRAR

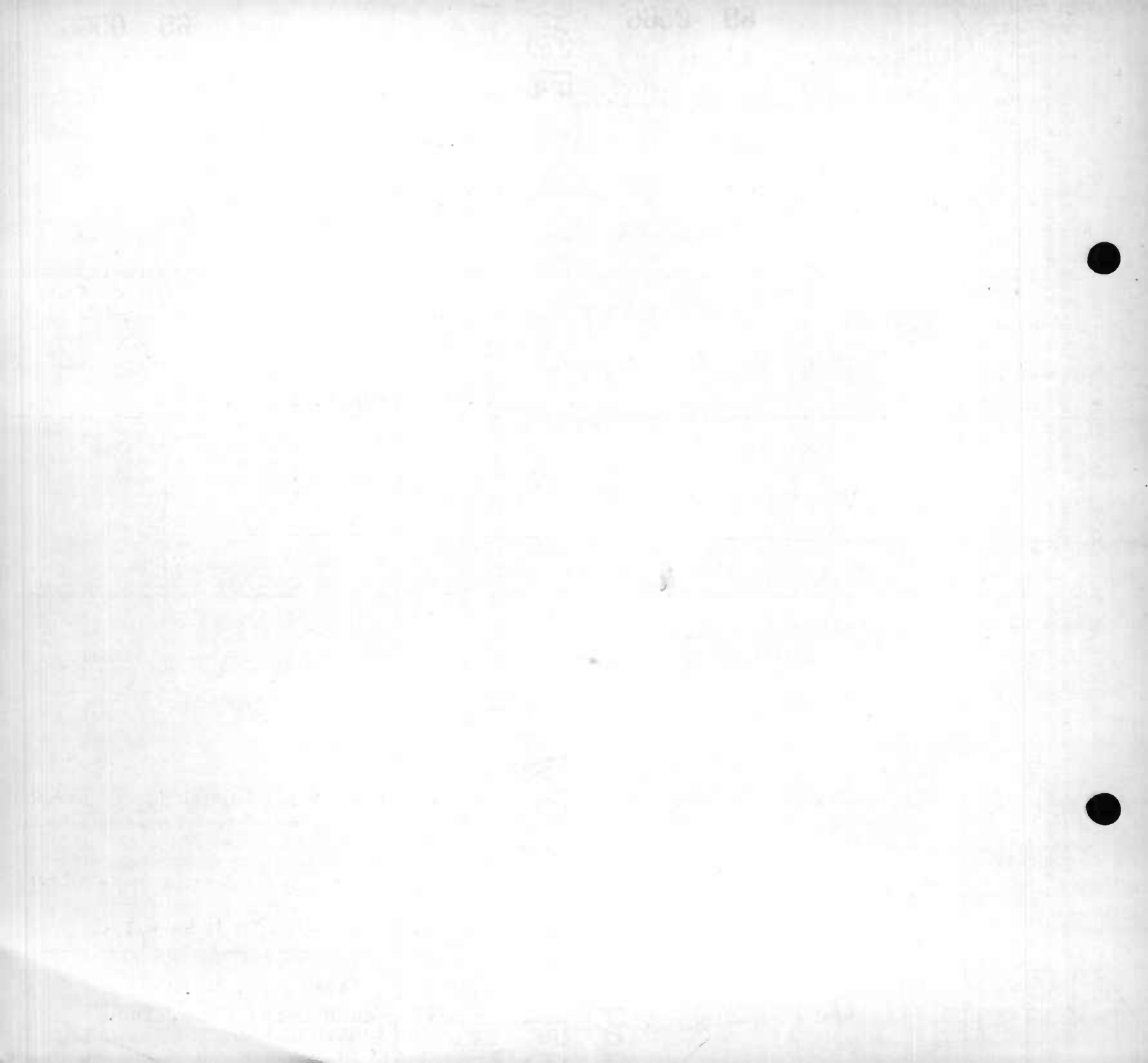
Robert E. Taylor

25C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.

ADDRESS

3331 Brehms Lane



FUNERAL DIRECTOR: IMPORTANT

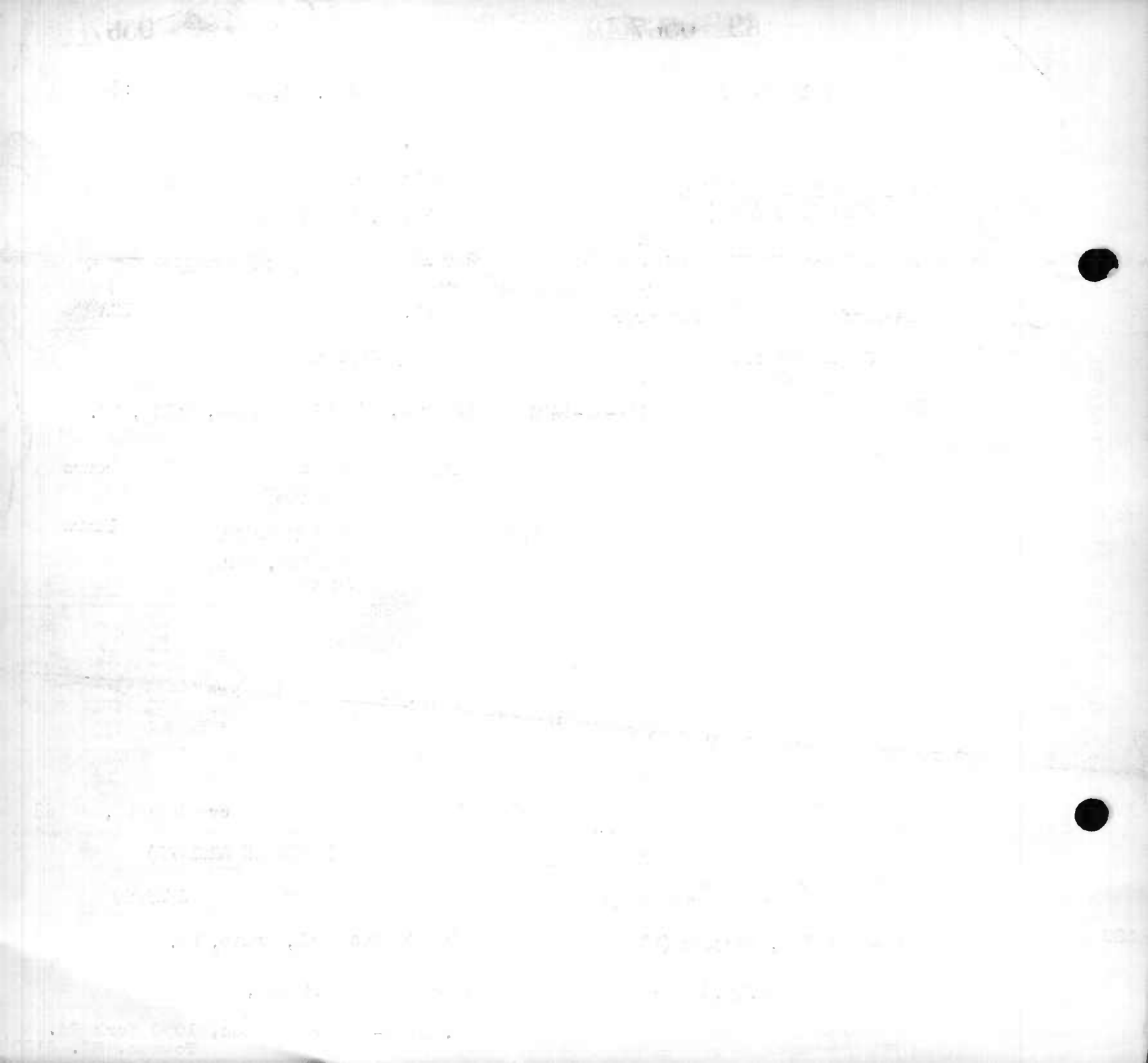
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0567

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 05671

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>GUY BECKETT</b>		2. DATE AND HOUR OF DEATH <b>Jan. 14, 1969</b> <b>7:48</b> <b>A</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>12-06</b>		5. SEX <b>M</b> 6. RACE <b>W</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>SOUTH BALTIMORE GENERAL</b> <b>(DEAD ON ARRIVAL)</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>217 W. 29th Street</b>		7. MARried <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/9/11</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Seafarer</b>		9. AGE (In years last birthday) <b>57</b>	
11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
13. FATHER'S NAME <b>James Beckett</b>		14. MOTHER'S MAIDEN NAME <b>Daisy Callias</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>216-10-5424</b>		17. INFORMANT <b>Records, US PHS Hospital, Balto, Md.</b>		ADDRESS	
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Pulmonary edema</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic coronary artery</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>disease, very severe</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b> <b>Years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>yes</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 17</b> 19 <b>68</b> to <b>November 18</b> , 19 <b>68</b> . that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 18</b> 19 <b>68</b> and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death. ( <b>DEAD ON ARRIVAL</b> )					
23A. SIGNATURE <b>Henry J. Babitt, MD</b>		23B. DATE SIGNED <b>1/15/69</b>		23C. PHYSICIAN'S NAME (Type) <b>Henry Babitt, Surgeon (R)</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>CREMATION</b>		24B. DATE <b>Jan. 17, 69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Green Mount Crematory</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>Wm. Cook-Brooks</b>		25D. ADDRESS <b>Towson, Md. 21204</b>		25E. ADDRESS <b>1050 York Rd.</b>	





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

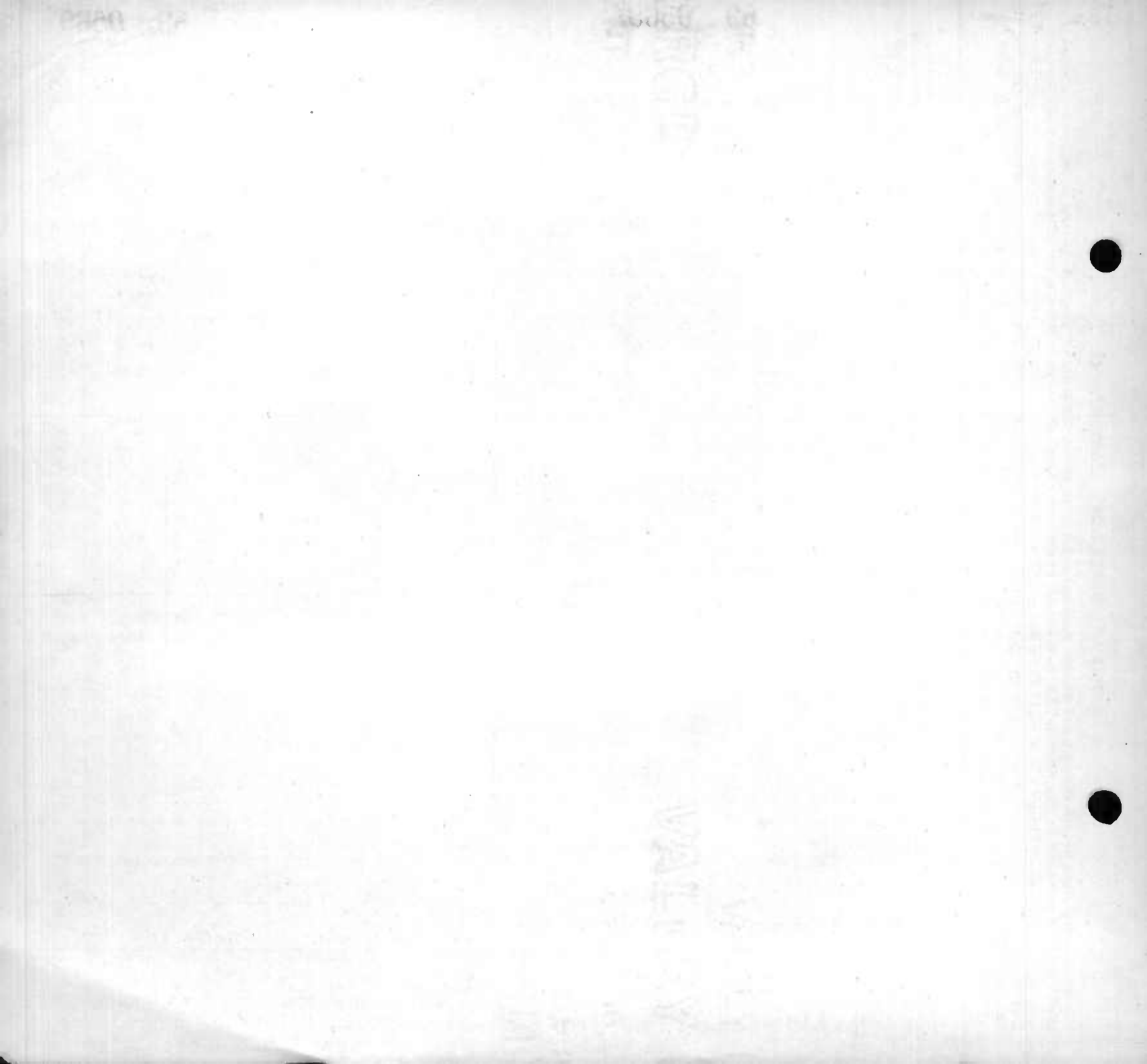
1. NAME OF DECEASED (Type or Print) <b>Leonard Warren</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 1 12 69 10:05 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>38 University Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 12, 1969 10:05 p.m.</b>	
6. SEX <b>Male</b>		7. RACE <b>Colored</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>6/6/14</b>		10. AGE (In years last birthday) <b>54</b>	
11. BIRTHPLACE (State or foreign country) <b>Chestertown Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME <b>Bertha</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>yes WW 2</b>	
17. SOCIAL SECURITY NO. <b>214-18-2458</b>		18. INFORMANT <b>MRs Aloha Warren</b>	
19. <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Edward F. Wilson</b> EXAMINER'S NAME (Type)		DATE SIGNED <b>1/13/69</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1/18/69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>National Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>T. Carroll</b>		ADDRESS <b>Halstead Funeral Home 1206 W North Ave</b>	

• 27 •

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>69 0569</b>
BIRTH NO.		<b>69 0569</b>		
1. NAME OF DECEASED (Type or Print) <b>BESSIE RICH</b>		2. DATE AND HOUR OF DEATH <b>JAN. 13, 1969 8:05 A. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 Ashburton Nursing Home</b> <b>3520 Hilton St</b>		A. STATE <b>Md</b> B. COUNTY <b>15-11</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>3520 Hilton St</b>				
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>90 ?</b>	9. AGE (In years last birthday) <b>90 ?</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME		
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs Mary Smith</b>		
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Coronary occlusion</b> (B) <b>Aortic stenosis</b> (C) <b>unknown</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>Aug. 21, 1968</b> to <b>Jan. 13, 1969</b> , that (I) <del>we</del> last saw the deceased alive on <b>Jan. 7, 1969</b> and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>We did</del> (did not) view the body after death.				
23A. SIGNATURE <b>Abraham B. Hurwitz M.D.</b>		23B. DATE SIGNED <b>Jan. 13, 1969</b>		23C. PHYSICIAN'S NAME (Type) <b>ABRAHAM B. HURWITZ MD</b>
23D. ADDRESS <b>7501 Liberty Rd. Baltimore, Md.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>1/17/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>MT Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>I Carroll, Halstead Funeral Home</b>
ADDRESS <b>1206 W North Ave</b>				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 0570				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 0570	
1. NAME OF DECEASED (Type or Print) <b>OSSIE SMITH</b>				2. DATE AND HOUR OF DEATH <b>1/13/69 - 1<sup>48</sup> PM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MARYLAND GENERAL HOSP.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>12-06</b>			
5. SEX <b>FEMALE</b>		6. RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/4/31</b>	
9. AGE (In years lost birthday) <b>37</b>		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WAITRESS</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>	
13. FATHER'S NAME <b>SAM SMITH</b>				14. MOTHER'S MAIDEN NAME <b>PEARL SCOTT</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>135-22-9155</b>		17. INFORMANT <b>Chart,</b>	
18. <b>282.5 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute Renal Failure secondary to Hemolytic Anemia</b>  (B) <b>Pneumonia sec to Aspiration</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) <b>Hemolytic Anemia from SC Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  <b>8 days</b>  <b>5 days</b>  <b>?</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Suspected Chronic Renal Disease</b>							
19A. DATE OF OPERATION <b>0 Done</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>—</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>—</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>1/2</b> 19 <b>69</b> to <b>Time of Death</b> , that (I) (we) lost saw the deceased alive on <b>1/13</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Marcia C. Schmidt M.D.</b>				23B. DATE SIGNED <b>1/13/69</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <b>MARCIA C. SCHMIDT M.D.</b>				23D. ADDRESS <b>MARYLAND GEN. HOSP., BALTIMORE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/18/69</b>		24C. NAME of CEMETERY or CREMATORY <b>MT Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>JAN 17 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Carroll, Halstead Funeral Home</b>		ADDRESS <b>1206 W North Ave</b>	

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description of the  
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## 69 0571 CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED

HEIMBACH, ANDREW CHARLES

2. DATE AND HOUR OF DEATH

JANUARY 16, 1969 | 2:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

ST AGNES HOSPITAL

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

WILKENS &amp; CATON AVENUES

BALTIMORE MARYLAND 21229

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
MARYLANDB. COUNTY  
21228

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☐NO ☐

E. STREET AND NUMBER

3505 FOSTER AVENUE

26-09

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

03 10 93

9. AGE (In years lost birthday)

75

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Grand Jury Clerk

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

CONRAD, HEIMBACH

DEC 'D

14. MOTHER'S MAIDEN NAME

(MUTH) MARY

DEC 'D

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

217 16 7907

17. INFORMANT

RECORD'S BALTIMORE MD 21229  
ST AGNES HOSPITAL WILKENS & CATON AVE

18. 560.9 I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE  
Pneumonia  
DUE TO, OR AS A CONSEQUENCE OF:

48 hours

(B) Intestinal obstruction  
DUE TO, OR AS A CONSEQUENCE OF:

6-8 days

(C) \_\_\_\_\_

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from JANUARY 15, 1969, to JANUARY 16, 1969, that (X) (we) last saw the deceased alive on JANUARY 16, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S NAME (Type)

RAYMOND J DONOVAN, JR

Attending Phys. ☒Med. Director ☐Staff Phys. ☐

23B. DATE SIGNED 16 69

23D. ADDRESS

BALTO NATL XXXXXXXXXXXXXXXXXXXX  
ST AGNES HOSPITAL WILKENS & CATON AVE  
MD XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1-18-1969

24C. NAME OF CEMETERY or CREMATORY

Sacred Heart

24D. LOCATION

Baltimore County, Maryland

(City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 17 1969

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Lilly &amp; Zeiler Inc. 1901-07 Eastern Ave.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CORA FOSTER

2. DATE OF DEATH Known ☒ Month Day Year Hour  
Estimated ☐ January 15, 1969 M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Lutheran Hospital (DOA)

3. DATE PRONOUNCED DEAD Month Day Year Hour  
January 15, 1969 5:19 P. M.5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

16-07

6. SEX

Female

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Dec 21

10. AGE (In years last birthday)

22

11. If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

3221 Westmont Avenue

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Harold Thompson

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Harriett Burne

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL SECURITY NO.

18. INFORMANT

Harriett Thompson

ADDRESS

Scind

19. E816.1 I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Cerebro-cranial injuries  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

street

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

4600 blk Windsor Mill Rd. at Weatheredsvi  
ile Rd.

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 1-15-69 4:40 P.

22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Passenger in auto that overturned

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

January 16, 1969

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1-21-69

24C. NAME OF CEMETERY or CREMATORY

Mt Airy

24D. LOCATION (City, town, or county) (State)

Baltimore

MD

25A. DATE REC'D BY HEALTH DEPT.

JAN 17 1969

25B. NAME OF REGISTRAR

Robert E. Finkbeiner

25C. FUNERAL DIRECTOR

Elroy Oehlson 100 Brewster Rd

ADDRESS

VALLEY MOBILE

F-645

69 0573 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 0573

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>HOWARD FREEMAN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input checked="" type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Franklin Square Hospital (DOA) 1023 W. Baltimore Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 13, 1969 2:27 P.M.</b>	
6. SEX <b>male</b>	7. RACE <b>negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>Feb 10</b>		10. AGE (In years lost birthday) <b>70</b>	
11. BIRTHPLACE (State or foreign country) <b>Balti Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Refined</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes</b>		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME <b>Widiane Freeman</b>		15. MOTHER'S MAIDEN NAME <b>Margie Bonds</b>	
18. INFORMANT <b>Alise Woodland</b>		ADDRESS	
19. <b>571.8 I</b>		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		Fatty Alteration of the Liver (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>1-17-69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Balti Nat Cmt</b>		24D. LOCATION (City, town, or county) (State) <b>Balti Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fink</b>	
25C. FUNERAL DIRECTOR <b>Choy Wilson</b>		ADDRESS <b>1000 Chantilly</b>	

VALLEY POLICE

VALLEY HALL

20/10/1981

10/10/1981

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## 69 0574 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

69 0574

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Smith, Juliette</i>		2. DATE AND HOUR OF DEATH <i>1/15/69 4:35 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>20-01</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>BON Secours Hospital</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>22 N. Monroe Street</i>		5. SEX <i>F</i>		6. RACE <i>N</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12-25-99</i>		9. AGE (In years last birthday) <i>69</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Deceased</i>		14. MOTHER'S MARDEN NAME <i>Deceased</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>215-09-5296</i>		17. INFORMANT <i>front sheet of Pt's chart</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>congestive heart failure</i> <i>diabetic</i> <i>progressive</i> <i>chronic heart failure + diabetic</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) _____					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12-27-68</i> to <i>1-15-69</i> , that (I) (we) last saw the deceased alive on <i>1-14-69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>H. Makipour</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>H. MAKIPOUR</i>		23D. ADDRESS <i>BON-SECOURS-HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-17-69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Balto Natl Cmt</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto Md 21219</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 17 1969</i>		25B. NAME OF REGISTRAR <i>Reg. B. E. Johnson</i>	
25C. FUNERAL DIRECTOR <i>E. Roy B. Wilson</i>		ADDRESS <i>519</i>			

AD 1560 84

3 July 1560

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>Victoria Smith</b>		2. DATE AND HOUR OF DEATH <b>13 Jan '69</b> <b>6:29 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>8-02</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b> <b>33</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>1603 N. BRADFORD STREET</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SE <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-30-15</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>53</b>
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES SMITH</b>		14. MOTHER'S MAIDEN NAME <b>LUCY BERNEY</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Edna Smith</b>		ADDRESS <b>Same</b>	
18. <b>62.1</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>hemoptysis</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>undifferentiated carcinoma of lung</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 1/2 hrs.</b> <b>8 hrs</b> <b>6 months</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Robert A. Norum M.D.</b>		23B. DATE SIGNED <b>13 Jan 69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Robert A. Norum, M.D.</b>		23D. ADDRESS <b>Johns Hopkins Hospital, Baltimore, Maryland</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-17-69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt Calvary Cmt</b>		24D. LOCATION (City, town, or county) (State) <b>A A County Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>	
25C. FUNERAL DIRECTOR <b>Shay &amp; Wilson</b>		ADDRESS <b>1001 Brantley Rd</b>	

3 Apr 68

Imore, Mary

Report D 11 Apr 68



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>RACHEL SIMPSON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input checked="" type="checkbox"/> <b>January 14, 1969</b> <b>12:00 AM</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1327 W. Fayette Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 14, 1969</b> <b>7:25 AM</b>	
6. SEX <b>female</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Jan 31-1895</b> <b>73</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) <b>73</b>		E. STREET AND NUMBER <b>1327 W. Fayette St.</b>	
11. BIRTHPLACE (State or foreign country) <b>Stromberg, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Saunders</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
15. MOTHER'S MAIDEN NAME <b>Mary Berger</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Elmer Simpson</b>	
19. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>No</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>1/14/69</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-18-69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Not known</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, Jr.</b>	
25C. FUNERAL DIRECTOR <b>Eloy Wilson</b>		ADDRESS <b>1000 Broomfield</b>	

85 0328

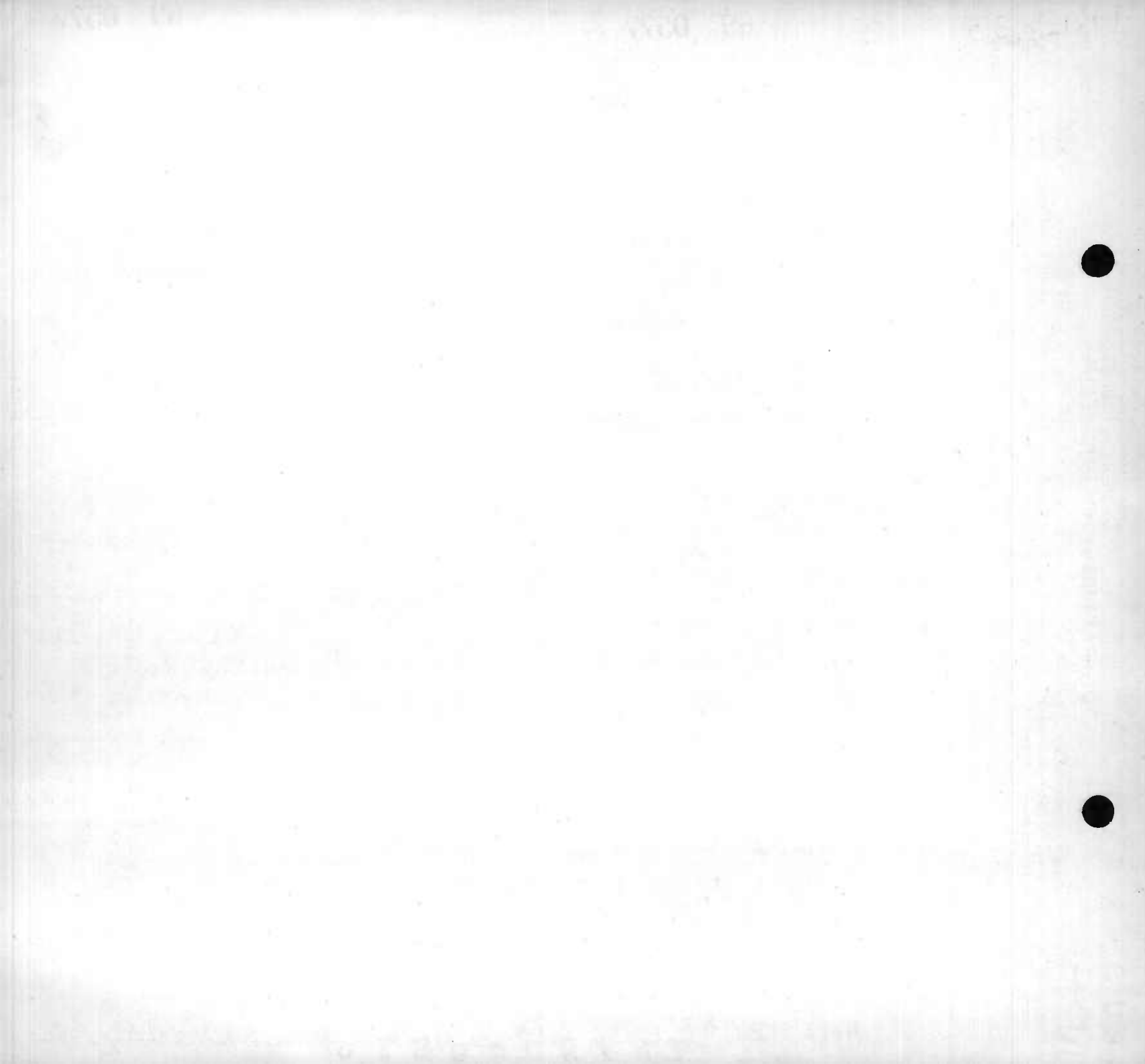
85 0328

WALLIS & GORDON  
VALLEY PHOTO  
25% OFF ALL  
PRINTS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

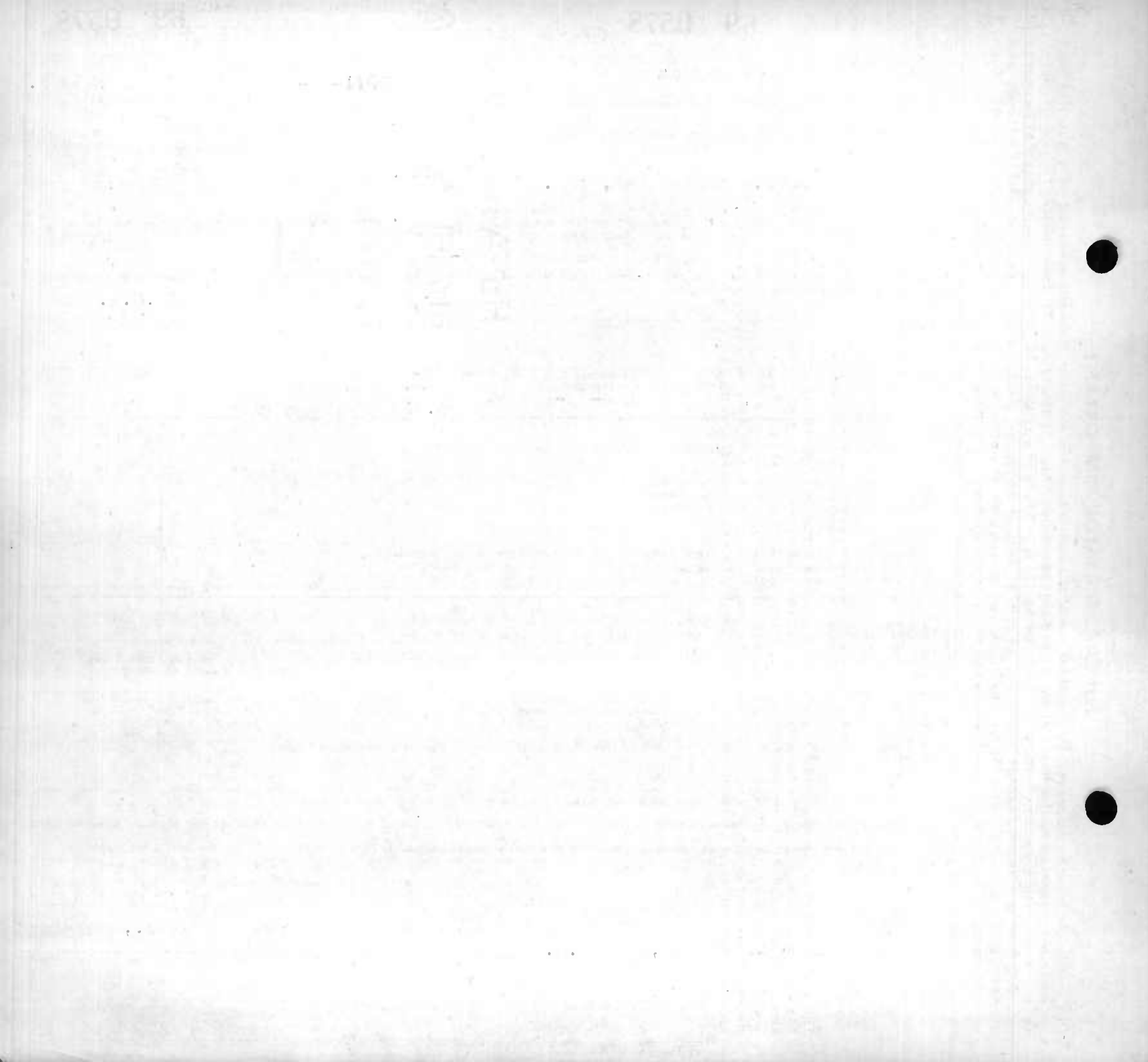
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
BIRTH NO.		69 0577		69 0577	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Martin Henrietta J		1-15-69		8:50 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
Lutheran Hosp. of Md.		A. STATE Md. B. COUNTY 16-05			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
46 Lutheran Hosp. of Md.		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		2412 West Tanvale St.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days
F	N	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	12/27/81	87	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
retired				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
William Bulter		Victor Bulter		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
no		216-09-4294		Alice Corbett	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		Chronic Brain Syndrome			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Due to Arteriosclerosis			
		(B) Diabetes M.			
		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 12-28 1968 to 1-15 1969, that (I) (we) last saw the deceased alive on 8:50 AM 1-15 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
H. L. Park M.D.				1-15-69	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Hyung Kyoung Park M.D.		Lutheran Hosp. of Md. Baltimore			
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1-18-69		Omitatus	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 17 1969		J. E. Ferguson		E. J. Johnson 1000 Brantley Rd	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 2549 69 0578		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 0578	
1. NAME OF DECEASED (Type or Print) Luther Person			2. DATE AND HOUR OF DEATH JAN-14-69 12:45 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 16-01 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1021 N. Carlton Street		
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-3-	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Georgia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME		
14. MOTHER'S MAIDEN NAME			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES		
16. SOCIAL SECURITY NO. 254-18-2151-A			17. INFORMANT Mrs. Emma Person Wife		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 20. AUTOPSY? (Yes or No) yes 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from January 13 19 69 to January 14 19 69, that (I) (we) lost saw the deceased alive on January 14 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE Virginia Y. Fausto M.D. DEGREE 23B. DATE SIGNED 1-14-69 23C. PHYSICIAN'S NAME (Type) Virginia Fausto, M.D. DEGREE 23D. ADDRESS 1514 Division Street Balto., Maryland 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 1-20-69 24B. DATE 1-20-69 24C. NAME of CEMETERY or CREMATORY Balto Natl Cmt 24D. LOCATION (City, town, or county) (State) Balto Md 25A. DATE REC'D. BY HEALTH DEPT. JAN 17 1969 25B. NAME OF REGISTRAR Robert E. Fausto 25C. FUNERAL DIRECTOR Joseph W. W. 1000 Brantly Ave ADDRESS					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT

## 69 0579 CERTIFICATE OF DEATH

REG. NO. 69 0579

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Thompson, Annie</i>		2. DATE AND HOUR OF DEATH <i>1-15-69 5:15 PM</i>		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>1537 Bond Street</i> B. COUNTY <i>8-07</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Dukeland Nursing And Convalescent Home</i> 1501 Dukeland St				C. CITY OR TOWN <i>Baltimore, Maryland</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F</i>		6. RACE <i>Negro</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1908</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>At home</i>		11. BIRTHPLACE (State or foreign country) <i>Culpepper, Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Wesley Jefferies</i>				14. MOTHER'S MAIDEN NAME <i>Anna Bell Davis</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>				16. SOCIAL SECURITY NO. <i>228-52-9220</i>		17. INFORMANT <i>Alice Holmes</i>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <i>12-8-66</i> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>1-15-69</i> 20A. AUTOPSY? (Yes or No) <i>NO</i> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>NO</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>?</i>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>12-8-66</i> to <i>1-15-69</i> , that (I) (we) last saw the deceased alive on <i>1-15-69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Thomas W. Harris, MD</i>						23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>THOMAS W. HARRIS, MD</i>				23D. ADDRESS <i>4200 Edmondson Ave Baltimore</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Removal</i>		24B. DATE <i>1-17-69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Ebenezer Baptist</i>		24D. LOCATION (City, town, or county) (State) <i>Culpepper, Va.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 17 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR <i>Randolph J. Collick</i>		25D. ADDRESS <i>2431 E. Oliver St</i>	

1902

Excessive the same

Excessive the same

Excessive the same

Excessive the same

1-17-04

Excessive the same

Excessive the same

Excessive the same

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Excessive the same



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0580

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 69 0580

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		WILLIAM KNOTTS		1/13/69 12 <sup>45</sup> A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL 33				A. STATE MARYLAND B. COUNTY BALTIMORE CITY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2322 E. OLIVER STREET	
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-19-11	9. AGE (In years last birthday) 57	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Chemical Co.		11. BIRTHPLACE (State or foreign country) Wadesboro, N.C.	
13. FATHER'S NAME PAUL KNOTTS		14. MOTHER'S MAIDEN NAME FEENEY WILLIAMS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-18-0625		17. INFORMANT ADDRESS William C. Knotts 2322 E. Oliver St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH 569.91 Renal Failure				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: Aspiration Pneumonia 3 days	
				(C) DUE TO, OR AS A CONSEQUENCE OF: GI bleeding 9 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Acute Abdominal Distention 3 hrs	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (the hospital) attended the deceased from 1/3/1969 to 1/13/1969 that (1) (we) last saw the deceased alive on 1/13/1969 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Edward Block MD				23B. DATE SIGNED 1/13/69	
23C. PHYSICIAN'S NAME (Type) Edward Block MD				23D. ADDRESS Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1-16-69		24C. NAME OF CEMETERY OR CREMATORY Knotts Cemetery	
24D. LOCATION (City, town, or county) (State) Removal		24E. DATE REC'D BY HEALTH DEPT. JAN 17 1969		24F. NAME OF REGISTRAR John E. Jenkins	
24G. DATE REC'D BY HEALTH DEPT. JAN 17 1969		24H. NAME OF REGISTRAR John E. Jenkins		24I. FUNERAL DIRECTOR Randolph C. Collick 2431 E. Oliver St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0581

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 0581

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Pearl V. Faul		January 15, 1969.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION  00 3013 Northern Parkway				A. STATE Md. B. COUNTY 27-45	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3013 Northern Parkway	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 17, 1878.	9. AGE (In years last birthday) 90	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John C. Dressel			14. MOTHER'S MAIDEN NAME Emma J. Sheffer		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-44-3273	17. INFORMANT Mr. John E. Magers, 1424 Fidelity Bldg. #01		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiac Arrest</i> (B) <i>Arteriosclerosis C.V. Disease</i> (C) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/24 1962 to 1/15 1969, that (I) (we) last saw the deceased alive on 1/11 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Nathan Jarney MD</i>				23B. DATE SIGNED 1/17/69	
23C. PHYSICIAN'S NAME (Type) Nathan Jarney				23D. ADDRESS 7101 Harford Rd. Balto., Md.	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/18/69.		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D. BY HEALTH DEPT. JAN 17 1969		25B. NAME OF REGISTRAR <i>Robert E. Farkner</i>		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214	

ORIGINAL

MAILED



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 0582

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JOHN L. NORTH Jr</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>January 16, 1969</b> Hour <b>9:25 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNIVERSITY HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 16, 1969 9:25 A.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Feb. 16, 1934</b>		10. AGE (In years last birthday) <b>34</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O RR</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>216-30-2328</b>	
15. MOTHER'S MAIDEN NAME <b>Katherine Register</b>		18. INFORMANT <b>Mae G North</b>	
19. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>2/1</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> DATE SIGNED <b>1/17/69</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/20/69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Seaberg</b>	
25C. FUNERAL DIRECTOR <b>Leonard J Ruck Inc.</b>		ADDRESS <b>Baltimore, Maryland</b>	

88-0033

88-0033

John L. Smith, Jr.

John L. Smith, Jr.

John L. Smith, Jr.

John L. Smith, Jr.

John L. Smith, Jr.

John L. Smith, Jr.

John L. Smith, Jr.

WALTER H. ROY

WALTER H. ROY

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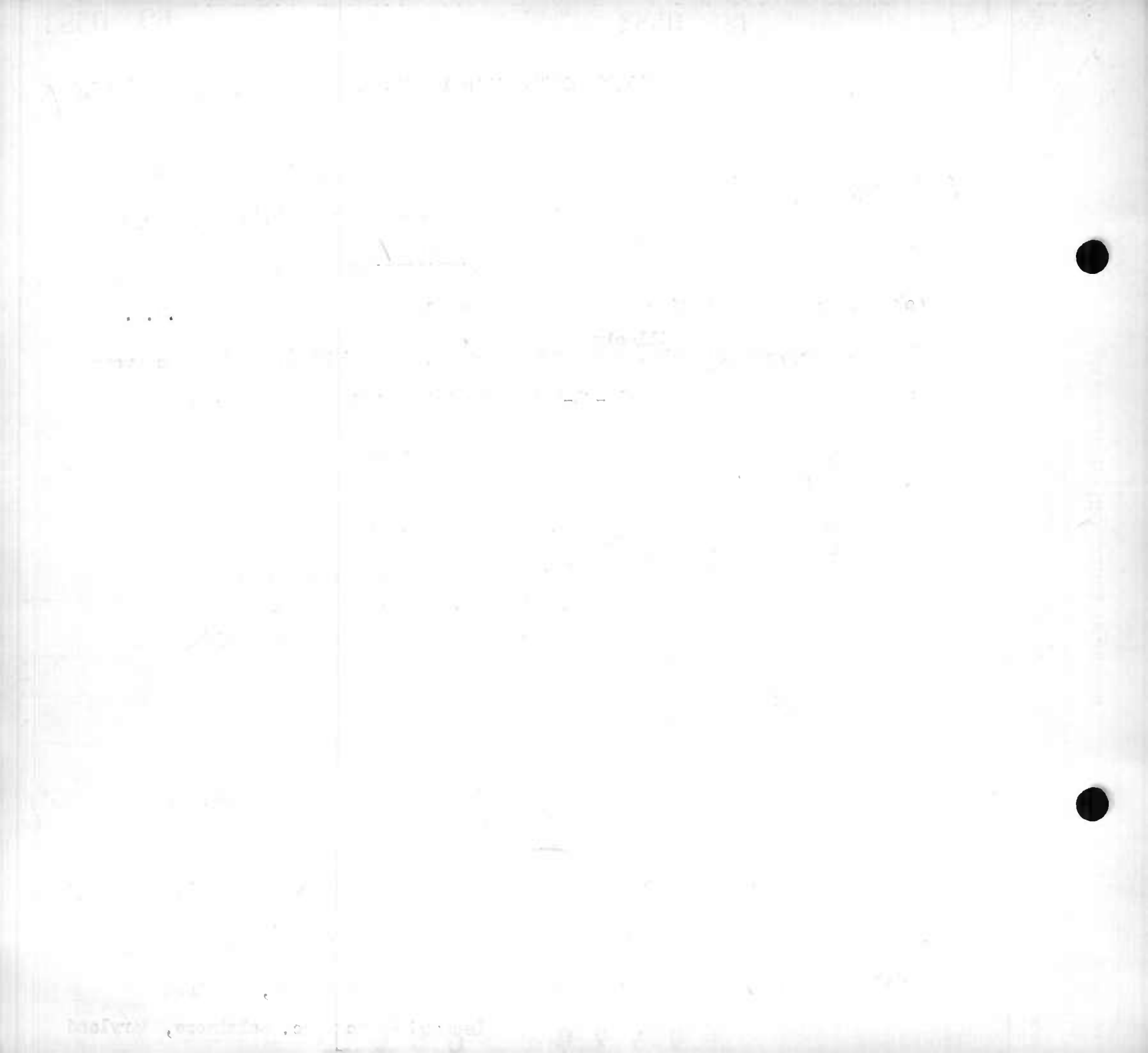
WALTER H. ROY

WALTER H. ROY

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0583		BALTIMORE CITY HEALTH DEPARTMENT		69 0583	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>JAMES P. <del>XXXXXXXXXX</del> Gillooly Sr</u>		2. DATE AND HOUR OF DEATH <u>JAN. 15, 1969 1 2150 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>8-07</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>MERCY HOSPITAL</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>1772 HOMESTEAD</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 10/02</u>	9. AGE in years (last birthday) <u>66</u>	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book Binder</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>JAMES <del>XXXXXXXXXX</del> Gillooly</u>		14. MOTHER'S MAIDEN NAME <u>ANNA <del>XXXXXXXXXX</del> Mc Avoy</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No,</u>		16. SOCIAL SECURITY NO. <u>216-03-0935</u>		17. INFORMANT <u>Virginia M Gillooly</u> ADDRESS <u>Same</u>	
18. <u>257X</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>LOBAR PNEUMONIA</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>FEW DAYS</u>		II DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>GENERAL DEBILITY</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>HYPOGLYCEMIA INDUCED</u> (C) <u>CEREBRAL DAMAGE</u> <u>CYSTITIS, DUODENAL ULCER</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>1</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>OCTOBER 31, 1968</u> to <u>JAN. 15, 1969</u> that (I) (we) last saw the deceased alive on <u>JANUARY 15, 1969</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>P. Saland M.D.</u>		23B. DATE SIGNED <u>JAN 16, 1969</u>		23C. PHYSICIAN'S NAME (Type) <u>PONCIANO V. SALAND M.D.</u>	
23D. ADDRESS <u>MERCY HOSPITAL</u>		23E. DEGREE <u>DEGREE</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/20/69</u>		24C. NAME of CEMETERY or CREMATORY <u>New Cathedral</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 17 1969</u>			
25B. NAME OF REGISTRAR <u>Robert E. [unclear]</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc.</u> ADDRESS <u>Baltimore, Maryland</u>			

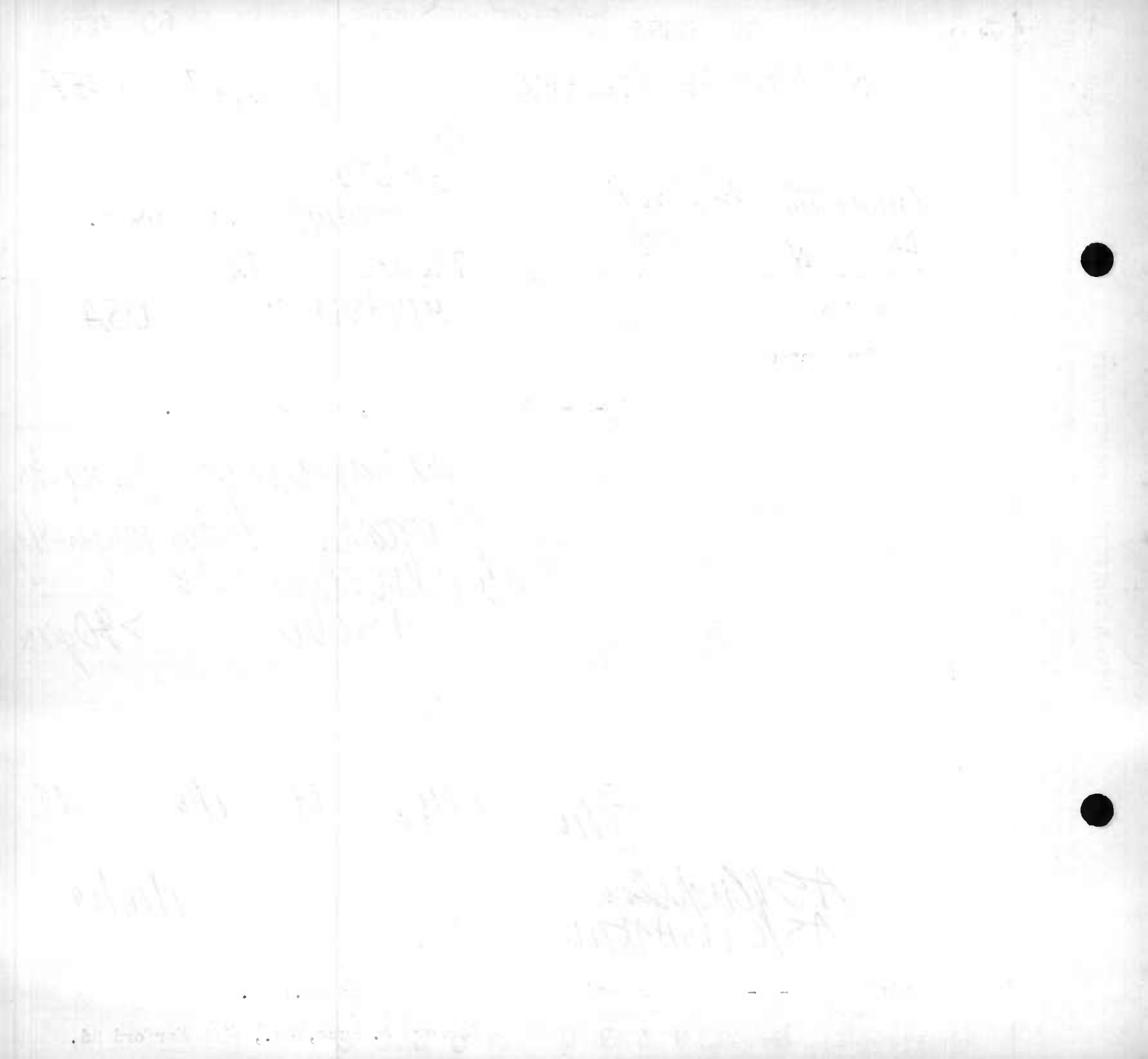




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				69 0584		REG. NO. 69 0584	
CERTIFICATE OF DEATH							
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>KATHERINE POLOKOW</b>				2. DATE AND HOUR OF DEATH <b>1/16/69 1125P</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>University Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>14-01</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>University Hospital</b>				C. CITY OR TOWN <b>BALTO</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>1829 Eutam Pl.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. <del>MARRIED</del> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/16/196</b>	9. AGE (in years last birthday) <b>72</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ilya Huczko</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>131-07-4181</b>		17. INFORMANT <b>Elsie Krauk, 6216 Walther Ave.</b>		ADDRESS	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  20A. AUTOPSY? (Yes or No)  20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Vent tachycardia &amp; Fib</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial infarction</b> (C) <b>Acute pulm. edema 2nd to A+B</b>  <b>ASCVD</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>few minutes</b> <b>going on - 4 days</b> <b>&gt; 40 years</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1/16/69</b> to <b>1/16/69</b> that (I) (we) last saw the deceased alive on <b>1/16/69</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>AS G LUSHAKOW</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>1/16/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>AS G LUSHAKOW</b>				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-20-69</b>		24C. NAME of CEMETERY or CREMATORY <b>Parkwood</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1969</b>		25B. NAME OF REGISTRAR <b>John E. Jankowski</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 69 0585

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Elsie Wagner</i>		2. DATE AND HOUR OF DEATH <i>1/15/69 8:05 P M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>8-31</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>48 Maryland General Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>2844 Kentucky Ave.</i>	
5. SEX <i>7</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7-1-98</i>	9. AGE (In years last birthday) <i>70</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Seamstress--Textile Industry</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>BAIT. MD.</i>	
13. FATHER'S NAME <i>George Jones</i>		14. MOTHER'S MAIDEN NAME <i>Ida. Unleback</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>216-07-7324</i>		17. INFORMANT <i>Patient's Hosp. Record</i>	
18. <i>436.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <i>II</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>hours</i>	
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pneumonia</i>	
				(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Corebrovascular Accident</i>	
				(C) <i>18 months</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1/14</i> 19 <i>69</i> to <i>1/15</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>1/15</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Louis E. Grenzer MD</i>				23B. DATE SIGNED <i>1/15/69</i>	
23C. PHYSICIAN'S NAME (Type) <i>Louis E. Grenzer MD</i>				23D. ADDRESS <i>Baltimore Md. General Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/18/69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i>	
				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 18 1969</i>		25B. NAME OF REGISTRAR <i>Leonard J. Ruck, Inc. Balto. Md. 21214</i>		25C. FUNERAL DIRECTOR ADDRESS <i>0504</i>	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 69 0586 CERTIFICATE OF DEATH

REG. NO.

69 0586

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Mr Carlo Crispino

2. DATE AND HOUR OF DEATH

January 16, 1969 11:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

The Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Md.

Baltimore.

12-03

C. CITY OR TOWN

Baltimore.

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

340 East 27th Street.

5. SEX

Male.

6. RACE

White.

7. MARRIED ☐

NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

01-06-77

9. AGE (In years last birthday)

92

11 Under 1 Yr.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Trackman

10B. KIND OF BUSINESS OR INDUSTRY

Penn. R.R.

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Crispino

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

717-07-6354

17. INFORMANT

ADDRESS

Mrs. Peter Cacano, 340 E. 27th St.

18.

412.4 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ABCVD

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

PNEUMONIA

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/11 19 69 to 1/16 19 69

that (I) (we) last saw the deceased alive on 1/16 19 69 and that (in my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Allen D. Jensen

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1/16/69

23C. PHYSICIAN'S NAME (Type)

ALLEN D. JENSEN, M.D.

DEGREE

23D. ADDRESS

UNION MEM. HOSP.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1-20-69

24C. NAME of CEMETERY or CREMATORY

Holy Redeemer

24D. LOCATION (City, town, or county)

Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 21 1969

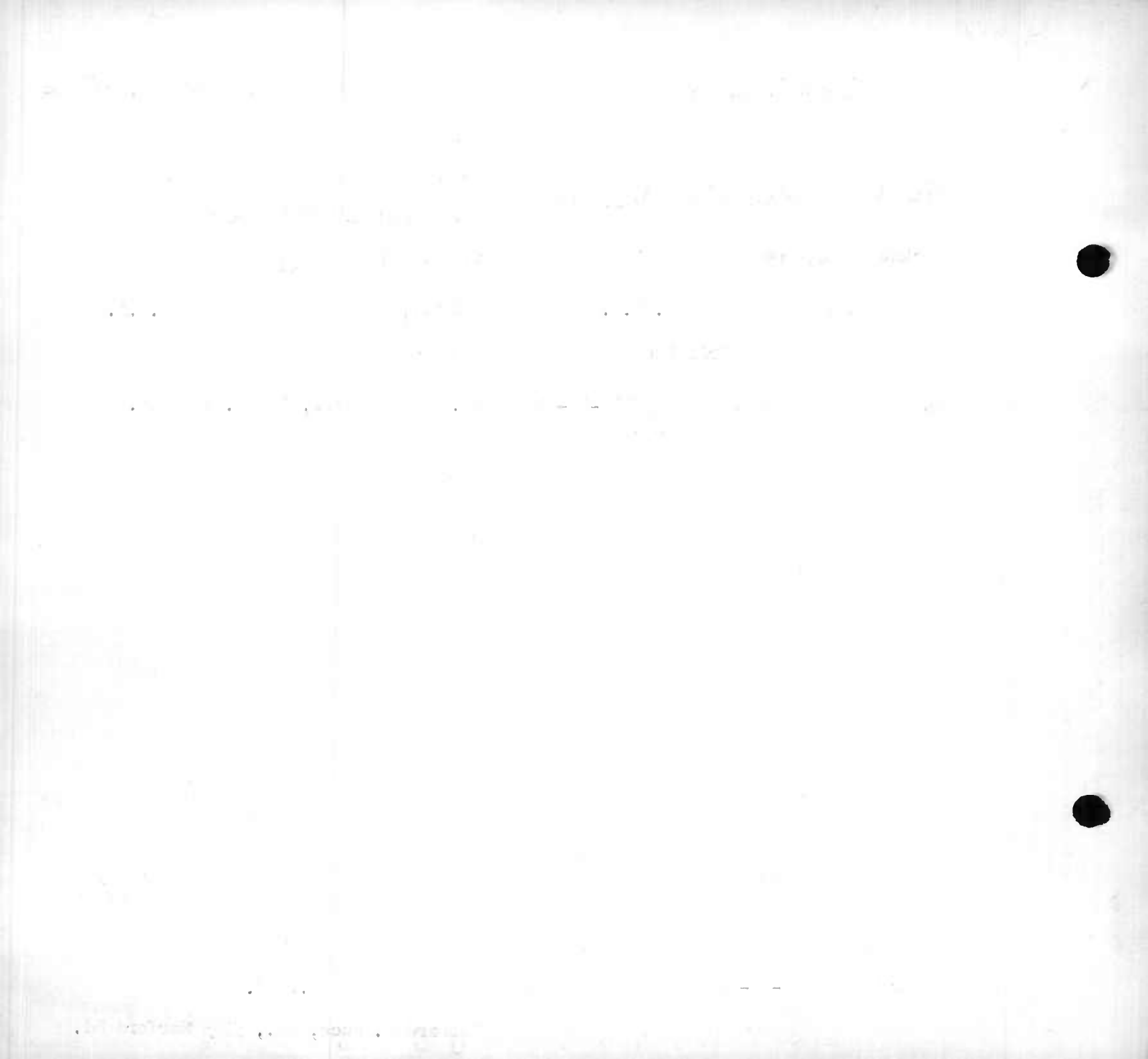
25B. NAME OF REGISTRAR

John C. Taylor

25C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc., 5305 Harford Rd.

ADDRESS



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 626				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 0587	
1. NAME OF DECEASED (Type or Print) <b>HARRY FREDERICK CROCKER</b>				2. DATE AND HOUR OF DEATH <b>JANUARY 15, 1969 11:05 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST AGNES HOSPITAL</b> <b>40</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>25-82</b>			
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>08 30 06</b>	
9. AGE (In years lost birthday) <b>62</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MAINTENANCE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry F. Crocker</b> <del>FRANK CROCKER</del>				14. MOTHER'S MAIDEN NAME <del>EMMA J. KIRBY</del> <b>Emma J. Kirby</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-01-2292</b>		17. INFORMANT <b>BALTO MD 21229</b> <b>ST AGNES RECORDS WILKENS &amp; CATON</b>			
18. <b>250.9 + 1571.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Necrotizing papillitis</b> (B) <b>Bilateral pyelonephritis</b> (C) <b>Diabetes mellitus</b>  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Laennec's cirrhosis</b>  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (IX) (this hospital) attended the deceased from <b>JANUARY 15 19 69</b> to <b>JANUARY 15 19 69</b> , that (IX) (we) last saw the deceased alive on <b>JANUARY 15 19 69</b> and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) not view the body after death.							
23A. SIGNATURE <b>Bert F. Morton, Jr.</b>				23B. DATE SIGNED <b>1-16-69</b>		23C. PHYSICIAN'S NAME (Type) <b>DR. BERT F. MORTON, M. D.</b>	
23D. ADDRESS <b>BALTO MD 21229</b> <b>ST AGNES HOSPITAL WILKENS &amp; CATON</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-20-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Pk.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>			

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M-635

69 0588 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 0588

BIRTH NO.

REG. NO.

1. NAME OF DECEASED  
(Type or Print)

GEORGE MORTON

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

January 16, 1969

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

January 16, 1969

10:20 A.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Pennsylvania

B. COUNTY

6. SEX

Male

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Bethlehem

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

3-22-07

10. AGE (In years  
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

435 Tawnee Street

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Chas. Morton

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Steel Worker

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Bertha Watson

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Claudine Poole 1403 Potomac

19. 412.2 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)Hypertensive and arteriosclerotic  
cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

January 16, 1969

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Removal

24B. DATE

1/18/69

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

Allentown, Pa.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 17 1969

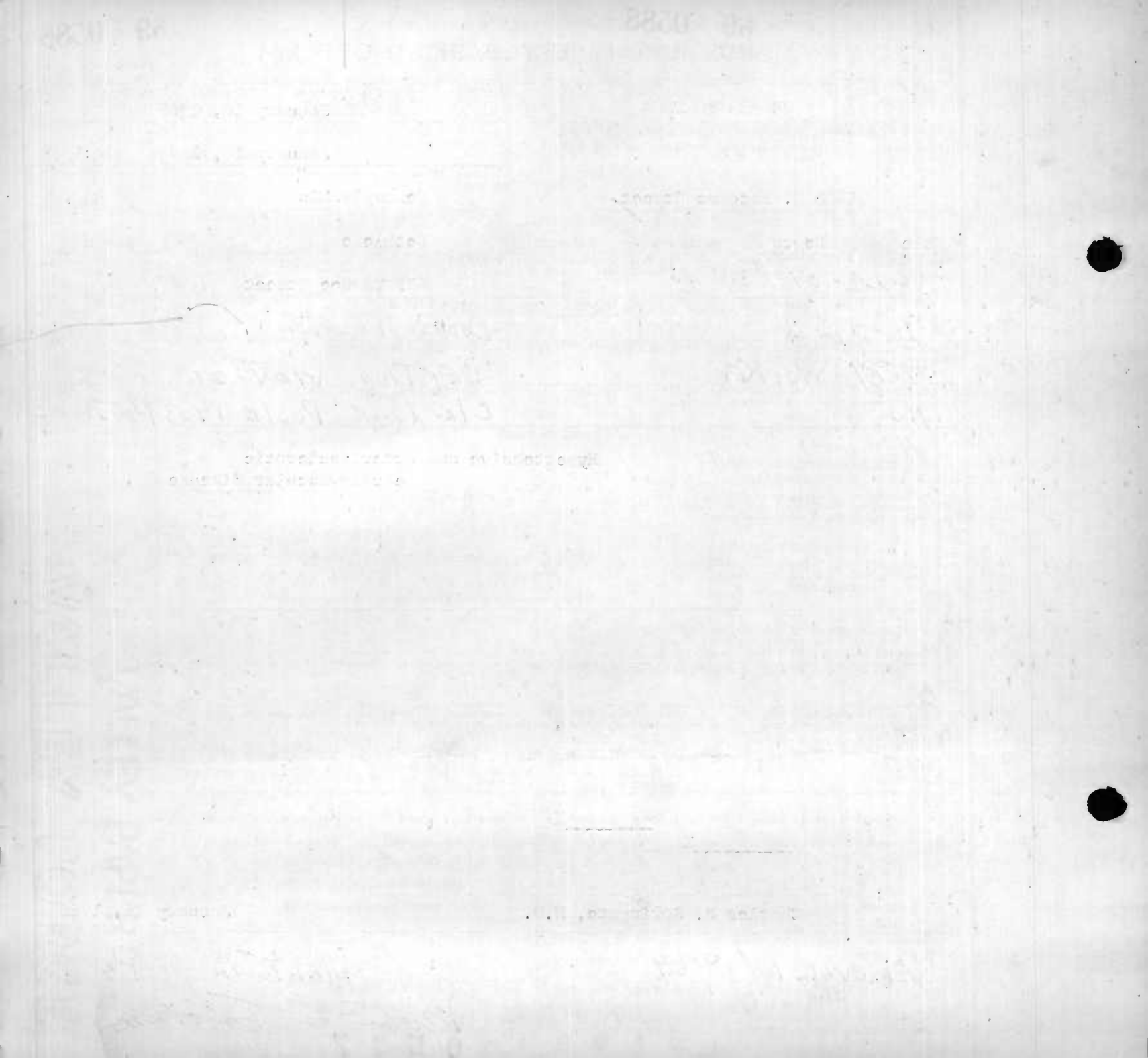
25B. NAME OF REGISTRAR

Robert E. Finkbeiner

25C. FUNERAL DIRECTOR

Milton E. Flickham

ADDRESS



H-200

69 0589

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

69 0589

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>HAYES, MOSES</b>		2. DATE AND HOUR OF DEATH <b>Jan 14 1969</b>   <b>5:00 AM</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE</b> <b>BALTIMORE, MARYLAND 21224</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>10-02</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>MALE</b>		6. RACE <b>NEGRO</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>3-9-18</b>	
13. FATHER'S NAME <b>James Hayes</b>		11. BIRTHPLACE (State or foreign country) <b>Wake County, N.C.</b>		9. AGE (In years last birthday) <b>50</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY? <b>Wake County, N.C.</b>	
17. INFORMANT <b>Lydia Hayes Lucas</b>		ADDRESS <b>21224</b>		BCH: RECORDS 4940 EASTERN AVE. BALTO. MD.	
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>CARCINOMA of the Stomach</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CARCINOMA of the Stomach</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 m</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from <b>1/1/69</b> 19 to <b>1/14/69</b> 19 that (1) (we) last saw the deceased alive on <b>1/14/69</b> 19 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <b>David Becker M.D.</b>		23B. DATE SIGNED <b>1/14/69</b>		23C. PHYSICIAN'S NAME (Type) <b>DAVID BECKER M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>1/16/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Wake Forrest, N.C.</b>	
24D. LOCATION (City, town, or county) (State) <b>Wake Forrest, N.C.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>	
25C. FUNERAL DIRECTOR <b>Robert E. Johnson</b>		25D. ADDRESS <b>4940 EASTERN AVE BALTO. MD.</b>		25E. ADDRESS <b>4940 EASTERN AVE BALTO. MD.</b>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

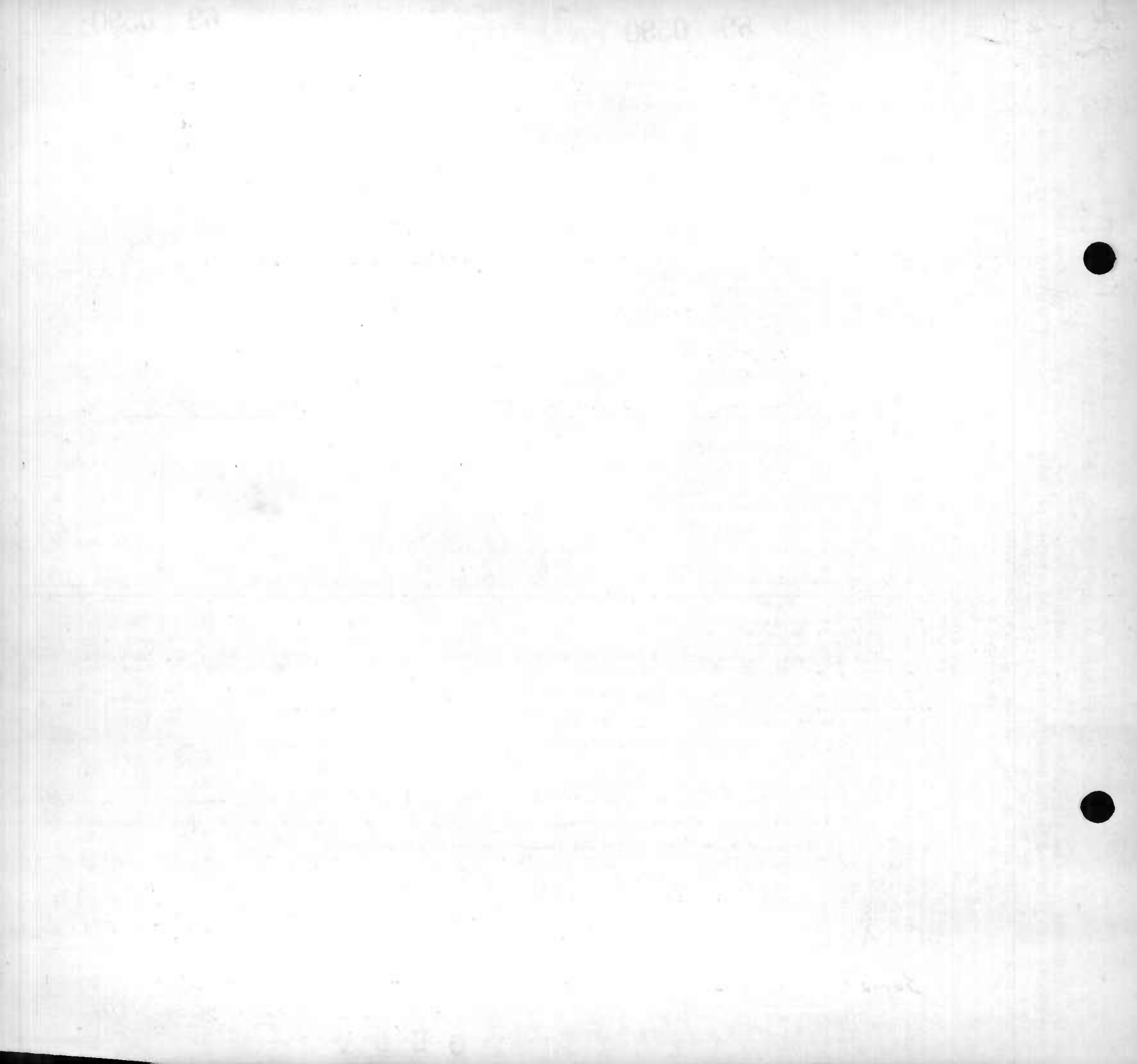
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT

## 69 0590 CERTIFICATE OF DEATH

REG. NO. 69 0590

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Elizabeth B. Oswald</i>		2. DATE AND HOUR OF DEATH <i>January 15, 1969</i>		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>00 1312 Hull ST.</i>				A. STATE <i>Maryland</i>		B. COUNTY <i>24-01</i>	
				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>1213 Hull ST.</i>							
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>5/22/92</i>		9. AGE (In years last birthday) <i>76</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cook</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Pearce Restaurant</i>		11. BIRTHPLACE (State or foreign country) <i>Hungary</i>		12. CITIZEN OF WHAT COUNTRY? <i>Hungary</i>	
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-03-8395E</i>		17. INFORMANT ADDRESS <i>Frank Oswald 1213 Hull ST.</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>250.9 I</i> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Crown Occlusion</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <i>Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF:		<i>2 yrs.</i>	
				(C) <i>Diabetes Mellitus</i>		<i>3 yrs.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 4</i> 19 <i>60</i> to <i>Jan 15</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>Jan 13</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>A. C. Sollod M.D.</i>						23B. DATE SIGNED <i>1-17-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>A. C. SOLLOD M.D.</i>		23D. ADDRESS <i>707 E. FORT AVE. BALTO., MD 21201</i>					
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/18/69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Cross Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Anne Arundel, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 17 1969</i>		25B. NAME OF REGISTRAR <i>Regina E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Charles E. Stevens Funeral Home, Inc.</i>		ADDRESS <i>5150 E. FORT AVE.</i>	



C-165

69 0591 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 0591

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES RUSSELL COBURN, SR.

2. DATE  
OF  
DEATHKnown ☒  
Estimated ☐

Month

Day

Year

Hour

January 15, 1969

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

4915 Midwood Avenue

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

January 15, 1969

4:45 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

27-10

6. SEX

Male

7. RACE

White

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

8/16/1890

10. AGE (In years  
last birthday)

78

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

4915 Midwood Avenue

11. BIRTHPLACE (State or foreign country)

Easton, Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Thomas H. Coburn

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired-Bricklayer

14B. KIND OF BUSINESS OR INDUSTRY

Construction

15. MOTHER'S MAIDEN NAME

Mary A. Adams

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

217-05-7300

18. INFORMANT

Mrs. Charlotte L. Coburn

ADDRESS

(Same)

19.

E935X

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Gunshot wound of mouth

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

home

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

4915 Midwood Avenue

22D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year)  
between 8:00 & 4:30 P. M.

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Shot self

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

January 16, 1969

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1/20/69

24C. NAME of CEMETERY or CREMATORY

Meadowridge Mem. Pk

24D. LOCATION

(City, town, or county)

(State)

Elkridge, Howard Co., Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 17 1969

25B. NAME OF REGISTRAR

Robert E. Finkbeiner

25C. FUNERAL DIRECTOR

H.W. Jenkins & Sons Co. 4905 York Rd.  
Balto. 12, Md.



1820 26

1820 26

ADAMS

20-1

18 20 18

ON 20-1

ADAMS

20-1



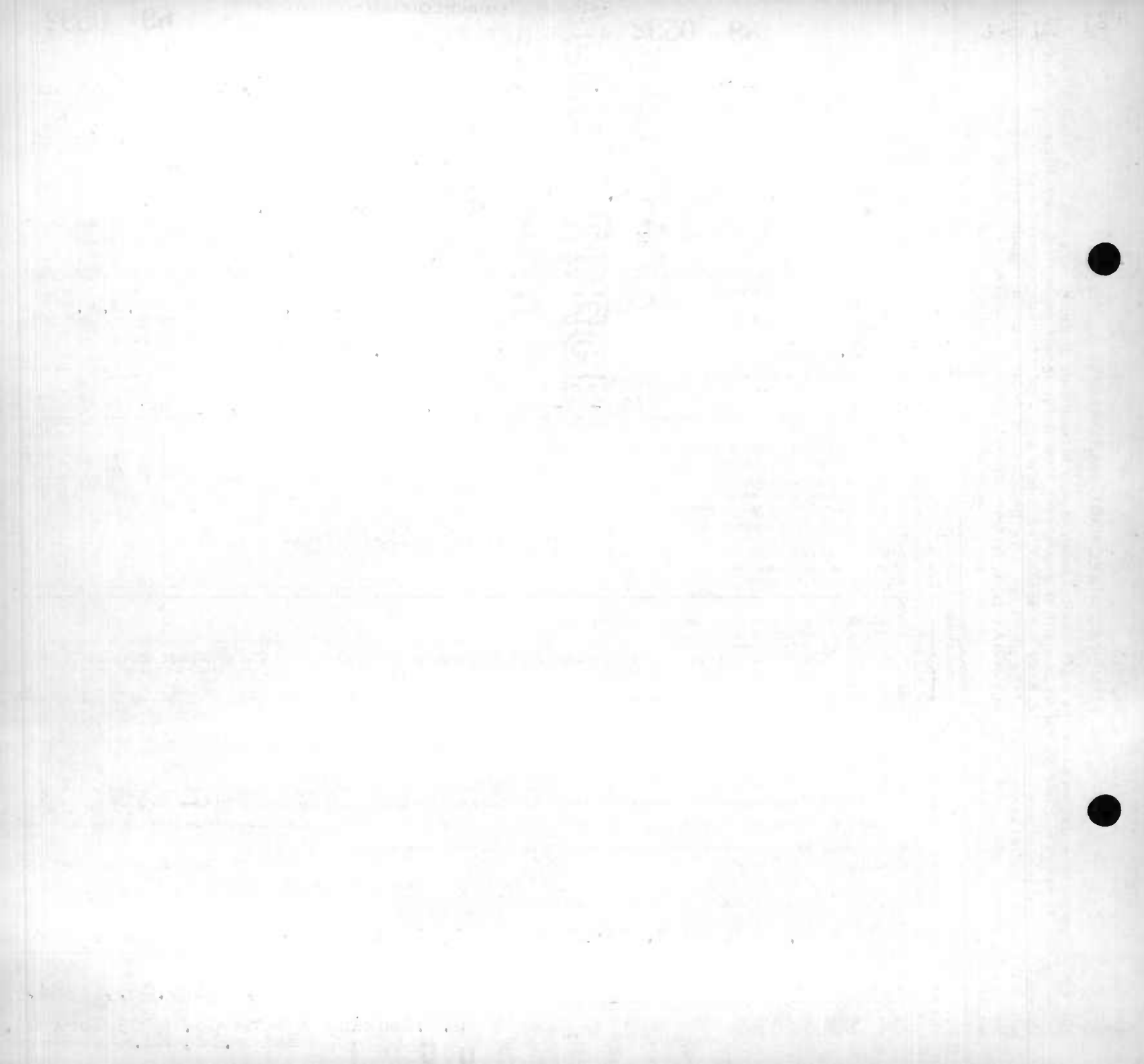
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 69 0592 CERTIFICATE OF DEATH

REG. NO. 69 0592

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Mildred L. Walker		January 15, 1969 8:00 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Maryland	
5902 Bellona Ave.				C. CITY OR TOWN Baltimore 21212	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 5902 Bellona Ave.			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/2/1896	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edwin F. Leister			
14. MOTHER'S MAIDEN NAME Ella M. Forsythe		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 213-38-5589		17. INFORMANT Mrs. Eleanor Serio, 543 Benninghaus Rd			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 410.9 I		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary occlusion (B) Coronary arteriosclerotic heart disease (C) unknown			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from Sept. 13, 1956 to Jan. 15, 1969, that (I) (we) last saw the deceased alive on Dec. 5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Abraham B. Hurwitz M.D.				23B. DATE SIGNED Jan. 17, 1969	
23C. PHYSICIAN'S NAME (Type) Dr. Abraham B. Hurwitz				23D. ADDRESS 7501 Liberty Road, BALTIMORE, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/18/69		24C. NAME OF CEMETERY or CREMATORY Woodlawn	
24D. LOCATION Woodlawn, Balto. Co., Md.		24E. DATE REC'D BY HEALTH DEPT. JAN 17 1969			
25A. NAME OF REGISTRAR Robert E. Jenkins		25B. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		25C. ADDRESS 4905 York Rd. Balto. 12, Md.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 0593	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>John M. Rosenberger Jr.</u>		2. DATE AND HOUR OF DEATH <u>Jan. 14, 1969 12:01 a. m.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Balto.</u>		C. CITY OR TOWN <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hosp.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>2032 Druid Park Dr.</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/26/48</u>	9. AGE (In years lost birthday) <u>20</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John M. Rosenberger</u>		14. MOTHER'S MAIDEN NAME <u>Ada Penner</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217 50 6349</u>		17. INFORMANT <u>John H Rosenberger Sr.</u>	
18. <u>207.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Leukemia</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C).....		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Jan. 11</u> 19 <u>69</u> to <u>Jan 14</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Jan 13</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Charles R. Goshen MD.</u>		23B. DATE SIGNED <u>1/14/69</u>		23C. PHYSICIAN'S NAME (Type) <u>CHARLES R. GOSHEN MD.</u>	
23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>1-16-69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Meridownridge Mem Pk</u>		24D. LOCATION (City, town, or county) (State) <u>Howard Co Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 17 1969</u>		25B. NAME OF REGISTRAR <u>Robert S. ...</u>		25C. FUNERAL DIRECTOR <u>Burgee Funeral Home Balto Md</u>	

$\approx 0.5 \text{ mm} \times 10^{-3} \text{ m} = 0.5 \times 10^{-6} \text{ m}$

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>69 0594</b>
69 0594		CERTIFICATE OF DEATH		
BIRTH NO.		2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print)		JANUARY 15, 1969 8:20 P M.		
FLORENCE E BALLARD				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY		
ST AGNES HOSPITAL CATON & WILKENS AVE BALTO MD 21229		MARYLAND ANNE ARUNDEL 52-00		
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH
				04 13 00
				9. AGE (In years last birthday) 68
				If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
HOUSEWIFE		OWN HOME		MARYLAND
12. CITIZEN OF WHAT COUNTRY?		U S A		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
WILLIAM R ZITTLE		FLORENCE M SCHAUR		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
NO		577 18 1092		Mrs. Olive Reinhardt (sister) same as #4 ST AGNES RECORDS-CATON & WILKENS AVE
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES		Atherosclerotic Heart Disease		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Pulmonary Congestion -		
		(C) Old Myocardial Infarction		
II		Liver cirrhosis, Diabetes Mellitus		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
2				YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
(Month) (Day) (Year) (Hour)		While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (X) (this hospital) attended the deceased from JAN. 6 1969 to JAN. 15 1969, that (X) (we) last saw the deceased alive on JAN. 15 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.				
23A. SIGNATURE				23B. DATE SIGNED
				1-16-69
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS
DR. SALVADOR QUIROZ - M.D.				ST. AGNES HOSPITAL WILKENS & CATON AVE.
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY
Burial		Jan. 20/69		Meadowridge Memorial Park
24D. LOCATION (City, town, or county) (State)		Glen Burnie, Maryland		
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS
JAN 17 1969				Singleton Funeral Home Glen Burnie, Maryland

1920

X

February

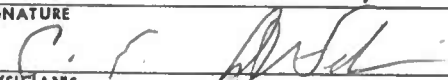
FUNERAL DIRECTOR: IMPORTANT

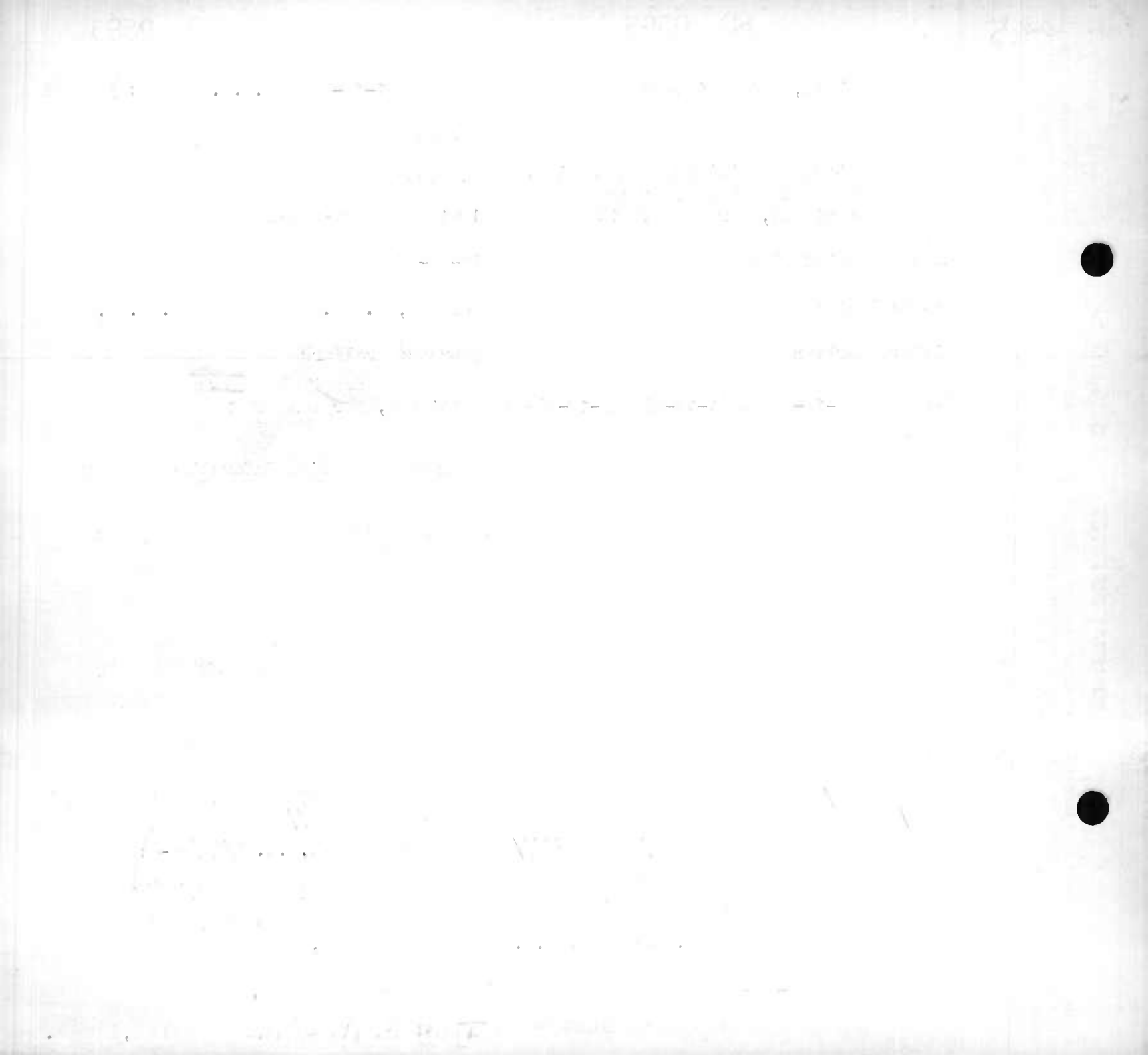
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0595

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 0595

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>WORKMAN, Teddy Vincent</b>		2. DATE AND HOUR OF DEATH <b>1-15-69 D.O.A. 4:25 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>26-34</b>		C. CITY OR TOWN <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>2349 Veterans Administration Hospital</b> <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>		E. STREET AND NUMBER <b>1001 Spangler Avenue</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-27-08</b>	9. AGE (In years last birthday) <b>60</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hospital Aide</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Cordova, W. Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Millard Workman</b>		14. MOTHER'S MAIDEN NAME <b>Florence Brellard</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 9-16-42 to 11-12-45</b>		16. SOCIAL SECURITY NO. <b>233-10-28-21</b>		17. INFORMANT <b>VA Hospital Records</b> <b>Baltimore, Maryland 21218</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Coronary Artery Disease</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>December 8th 1967</b> to <b>December 31st 1968</b> that (1) (we) last saw the deceased alive on <b>December 31st 1968</b> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death. <b>D.O.A. 1/15/69 4:25 AM</b>					
23A. SIGNATURE 		23B. DATE SIGNED <b>1/15/69</b>		23C. PHYSICIAN'S NAME (Type) <b>CHARLES E. DeFELICE, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-18-69</b>		24C. NAME of CEMETERY or CREMATORY <b>Bel Air Memorial Gardens</b>	
24D. LOCATION (City, town, or county) (State) <b>Bel Air, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 17 1969</b>		25B. NAME OF REGISTRAR <b>John H. Harkins</b>	
25C. FUNERAL DIRECTOR <b>John H. Harkins</b>		25D. ADDRESS <b>Delta, Penna.</b>			





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <span style="float: right;">69 0596</span>	
1. NAME OF DECEASED (Type or Print) <b>Guess, F. Herbert</b>			2. DATE AND HOUR OF DEATH <b>1-16-69</b> <b>5:00 p. m.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Provident Hospital</b> <b>1514 Division Street</b> <b>Baltimore, Maryland</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>14-02</b>		
5. SEX <b>Male</b>			6. RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>12/10/91</b>			9. AGE (In years last birthday) <b>77</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>COPPER WORKER</b>
11. BIRTHPLACE (State or foreign country) <b>SOUTH CAROLINA</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>NOT KNOWN</b>			14. MOTHER'S MAIDEN NAME <b>NOT KNOWN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>218-10-2246</b>		17. INFORMANT <b>Sarah Warren (Friend)</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>250.0 I</b> <b>Diabetic Mellitus</b> <b>uncontrolled</b> <b>Acidosis, Metabolic</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1-11-69</b> to <b>1-16-69</b> , that (I) (we) lost saw the deceased alive on <b>1-16-69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b>				23B. DATE SIGNED <b>1-17-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>E. T. T. Co MD</b>				23D. ADDRESS <b>Provident Hospital</b> <b>1514 Division Street - Baltimore, Maryland</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1/21/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>MT. AUBURN CEM.</b>	
24D. LOCATION (City, town, or county) <b>BALTIMORE, MD.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>		24F. NAME OF REGISTRAR <b>MARGARET BROWN</b>	
24G. FUNERAL DIRECTOR ADDRESS <b>3106 WALBROOK AVE</b>					



1  
B-400

69 0597 BALTIMORE CITY HEALTH DEPARTMENT

69 0597

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Philipp Ball</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> 1 17 1969 Hour 4:50 PM M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>34 Bon Secours Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour 1 17 1969 5:00 PM M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>20-02</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <b>Male</b>	7. RACE <b>C</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>FEB 1-1956</b>		10. AGE (In years lost birthday) <b>11</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES BALL</b>		14. MOTHER'S MAIDEN NAME <b>BEULAH JOHNSON</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		16. KIND OF BUSINESS OR INDUSTRY <b>Public Schools</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		18. SOCIAL SECURITY NO.	
19. CAUSE OF DEATH <b>ERIP. 9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Multiple injuries</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Catherine &amp; Lombard Sts.</b>		22D. HOW DID INJURY OCCUR? <b>fell under moving trailer and ran over by same.</b>	
22E. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>1 17 1969 4:50 PM</b>		22F. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>Jan 18, 1969</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/20/69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>BALFO NATIONAL</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>		25B. NAME OF REGISTRAR <b>John B. S. Fink</b>	
25C. FUNERAL DIRECTOR <b>Wm. H. &amp; Sons</b>		25D. ADDRESS <b>638 N. Gales St</b>	

1800 86

1800 86

WALLACE BROWN

1800 86

FUNERAL DIRECTOR: IMPORTANT

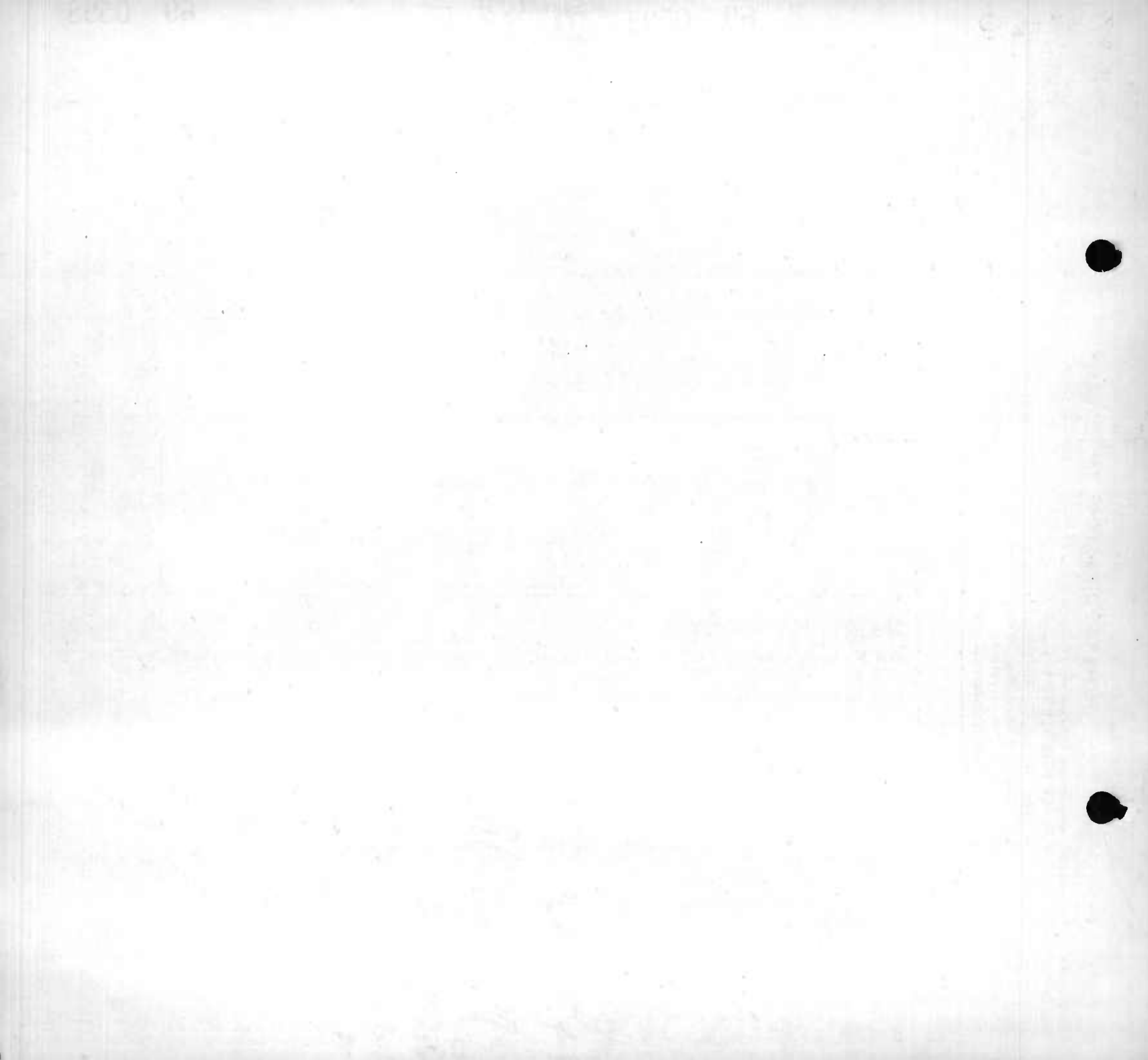
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0598

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 0598

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Kelly, Florinda E.</b>		2. DATE AND HOUR OF DEATH <b>1-16-69</b> <b>5<sup>40</sup></b> P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>46 Lutheran hospital of Maryland</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-38</b>		
			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>3304 N. Hilton HILTON ST</b>		
S. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>2-9-94</b>	9. AGE (In years last birthday) <b>74</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (State or foreign country) <b>BALTO MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
13. FATHER'S NAME <b>ROBERT KENNARD</b>			14. MOTHER'S MAIDEN NAME <b>SEDONIA STANLEY</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>D. R. BAHADORI M.D.</b> ADDRESS <b>Lutheran hospital</b>		
18. <b>151.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Carcinoma of stomach</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) <b>Carcinoma of stomach</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3:30 PM 1/14 1969</b> to <b>5:40 1/16 1969</b> , that (I) (we) last saw the deceased alive on <b>5 PM 1/16 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>D. R. Bahadori M.D.</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>REBA BAHADORI M.D.</b>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1/20/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>ARBUTUS MEM. PARK</b>	
				24D. LOCATION (City, town, or county) (State) <b>ARBUTUS - BALTO CITY MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>Manhwa G. Hym</b> ADDRESS <b>638 N. GILMAN ST</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 69 0599 CERTIFICATE OF DEATH

REG. NO.

69 0599

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ALICE L. DOTSON</b>		2. DATE AND HOUR OF DEATH <b>1/16/69 5:00 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND G.G.C. 52-00</b> B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION <b>49 NORTH CHARLES GENERAL HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>GLEN BURNIE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>F</b>		6. RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>8/22/22</b>		9. AGE in years last birthday <b>46</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>CHESTER OLIVER</b>	
14. MOTHER'S MAIDEN NAME <b>BLANCHE</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>DAVID DOTSON 286 THOMPSON AVE.</b>		18. CAUSE OF DEATH <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>CEREBRO-VASCULAR ACCIDENT</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>RUPTURED ANEURYSM</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1/9</b> 19 <b>69</b> to <b>1/16</b> 19 <b>69</b> , that (I) (we) lost saw the deceased alive on <b>1/16</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>David V. Santos M.D.</b>				23B. DATE SIGNED <b>1/16/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>LEONARD FLAX M.D.</b>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burnial</b>		24B. DATE <b>1/19/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Dorson's Family</b>	
24D. LOCATION <b>Glen Burnie P.A. Co MD</b>		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
24G. DATE REC'D BY HEALTH DEPT.		24H. NAME OF REGISTRAR		24I. FUNERAL DIRECTOR <b>Mamie P. Hays 635 N. Gilmer St</b>	





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C-160

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>CATHERINE COOPER</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input checked="" type="checkbox"/> <b>January 19, 1969 12:25 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD <b>January 19, 1969 12:25 A.M.</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>9-04</b>	
6. SEX <b>female</b>	7. RACE <b>negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>8/15/94</b>		10. AGE (In years last birthday) <b>75</b>		E. STREET AND NUMBER <b>2640 Boone St.</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Jeff C. Johnson</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		15. MOTHER'S MAIDEN NAME <b>Peggy Brown</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. CAUSE OF DEATH <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>No</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>1/19/69</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1/24/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. John Church Cemetery, Cobham, Va.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Johnson's Funeral Home, Orange, Va.</b>	

19690000599

W.C. Jones  
Bryce Canyon

020

8/14/94  
Bryce Canyon  
Utah

WALTER BOYD  
VALLEY CANYON

Walter Boyd

Walter Boyd  
Bryce Canyon  
Utah

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 69 0601 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 69 0601

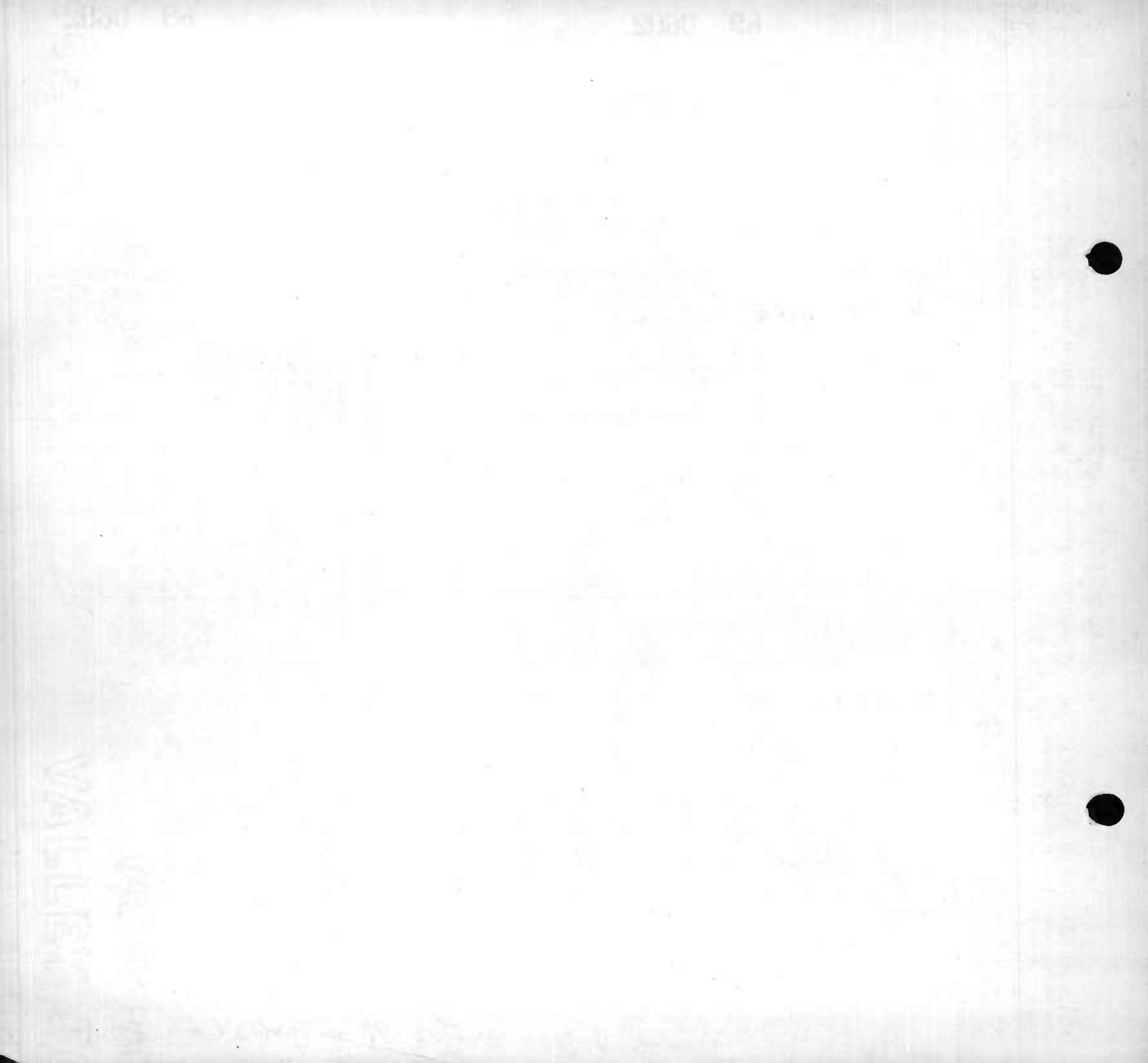
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>William Jesse Hoos</i>		2. DATE AND HOUR OF DEATH <i>1-16-69 8:30 P. M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>14-03</i>	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>00 1811 Madison Ave</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>1811 Madison Ave</i>		5. SEX <i>Male</i> 6. RACE <i>Colored</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH <i>May 1-1905</i>		9. AGE (In years last birthday) <i>63</i>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Porter</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Richard Hoos</i>		14. MOTHER'S MAIDEN NAME <i>Ella Garrison</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>212-69-3172</i>		17. INFORMANT <i>Ella Johnson 1811 Madison Ave</i>	
18. <i>412.31</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic Heart Disease</i> (B) <i>Chronic Nephritis</i> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 yr 3 mos</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>1-18-1968</i> to <i>1-16-1969</i> , that (I) (we) last saw the deceased alive on <i>1-16-69</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Franklin Phillips M.D.</i>		23B. DATE SIGNED <i>1/18/69</i>		23C. ADDRESS <i>558 No. Mochan St. Baltimore Md</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/20/69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt Calvary</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Balto Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 20 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>	
25C. FUNERAL DIRECTOR <i>V. Brooks Ruggold</i>		25D. ADDRESS <i>1463 N. Carey St</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

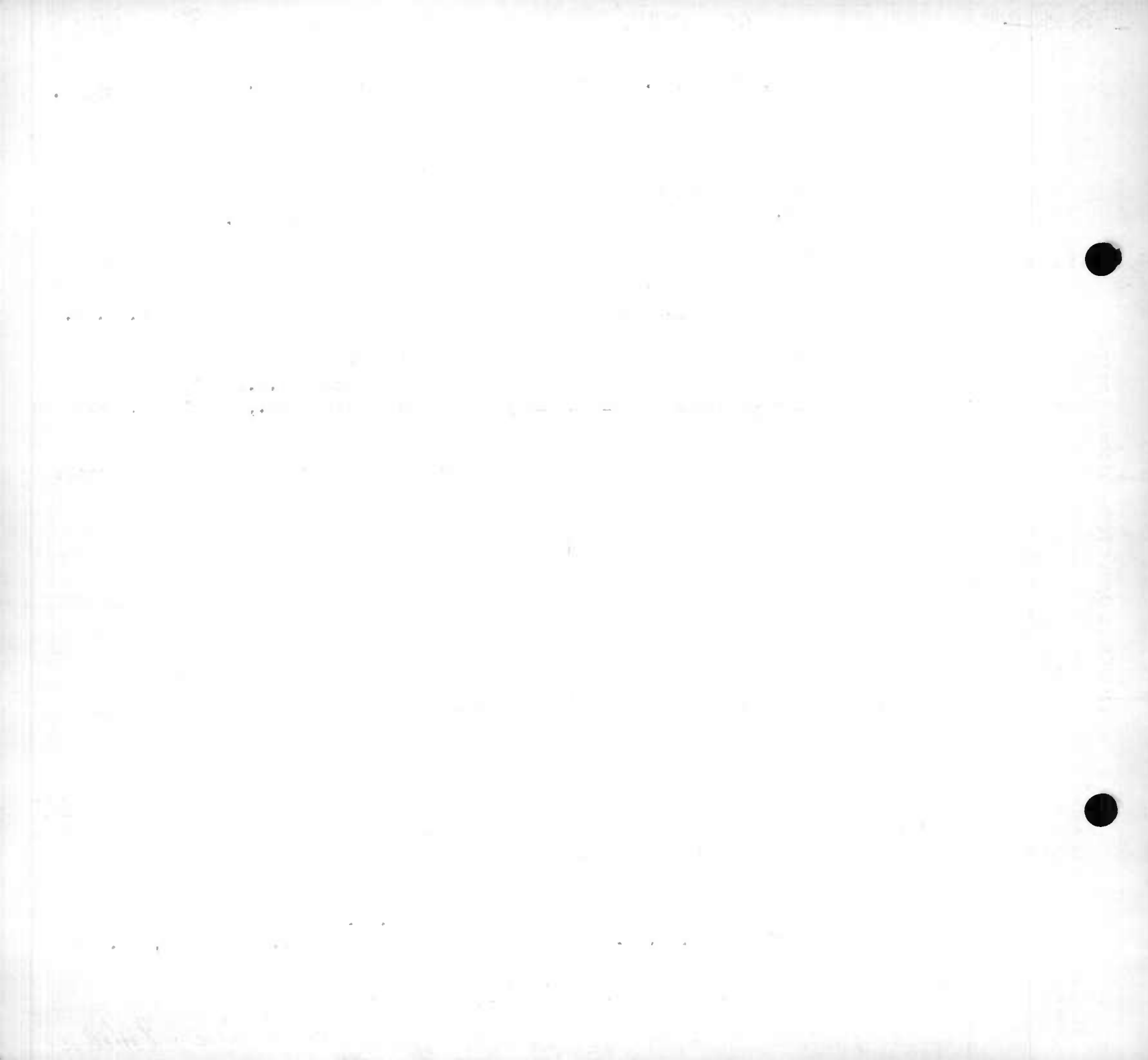
69 0602		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 69 0602	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>CATHERINE C. BURNS</b>			
2. DATE AND HOUR OF DEATH <b>1-16-69 4:15 P. M.</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION <b>LITTLE SISTERS OF THE POOR</b> <b>1200 VALLEY ST.</b> <b>BALTIMORE, MD., 21202</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Balt. Co.</b> <b>53-00</b>			
C. CITY OR TOWN <b>BALTIMORE</b>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <b>2705 GARNET RD.</b>							
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-12-88</b>	9. AGE (In years lost birthday) <b>80</b>	If Under 1 Yr. Months; Days		If Under 24 Hrs. Hours; Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>AMERICA</b>
13. FATHER'S NAME <b>ANTHONY SCHOEPPLEIN</b>			14. MOTHER'S MAIDEN NAME <b>MARGARET WISBECK</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>1</b>			16. SOCIAL SECURITY NO. <b>413-54-4374</b>		17. INFORMANT <b>LITTLE SISTERS OF THE POOR</b>		
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>C.U.A.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>A.S.C.O.D.</b>			CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1968</b> to <b>1-16-1969</b> , that (I) (we) lost saw the deceased alive on <b>Jan 16 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Stanley Ankudras</b>				23B. DATE SIGNED <b>1-18-69</b>			
23C. PHYSICIAN'S NAME (Type) <b>STANLEY ANKUDRAS</b>				23D. ADDRESS <b>1101 MAIDEN CHOICE LANE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/20/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>		25B. NAME OF REGISTRAR <b>Robert J. ...</b>		25C. FUNERAL DIRECTOR <b>Philip Herzig Sons Orleanno</b>		ADDRESS <b>2024</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0603		BALTIMORE CITY HEALTH DEPARTMENT		69 0603	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>LAWRENCE, Wilfred A.</b>			2. DATE AND HOUR OF DEATH <b>January 17, 1969 12:55 A.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Veterans Administration Hospital</b>			A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <b>3900 Loch Raven Boulevard</b>			C. CITY OR TOWN <b>Baltimore</b>		
<b>23 Baltimore, Maryland 21218</b>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <b>Male</b>			E. STREET AND NUMBER <b>5920 Southwestern Blvd.</b>		
6. RACE <b>Caucasian</b>			8. DATE OF BIRTH <b>2-20-1898</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. AGE (In years last birthday) <b>70</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		
10B. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Frank Lawrence</b>			14. MOTHER'S MAIDEN NAME <b>Cora Kieffer</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 4-27-17 to 9-22-19</b>			16. SOCIAL SECURITY NO. <b>213-03-20-90A</b>		
17. INFORMANT <b>Records V.A. Hospital</b>			ADDRESS <b>3900 Loch Raven Blvd., Baltimore, Maryland</b>		
18. CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of esophagus</b>					<b>6 Months</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>No</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Sept 23 1968</b> to <b>Jan 17 1969</b> that (I) (we) last saw the deceased alive on <b>Jan 17 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Robert A. Cordes</b>				23B. DATE SIGNED <b>1-17-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Robert Cordes, M. D.</b>				23D. ADDRESS <b>V. A. Hospital 3900 Loch Raven Blvd., Baltimore, Md. 21218</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/20/69</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore National Cem.</b>	
24D. LOCATION (City, town, or county) <b>Baltimore</b>		24E. STATE <b>Md.</b>		24F. COUNTRY <b>U.S.A.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>		25B. NAME OF REGISTRAR <b>John J. Gowan</b>		25C. FUNERAL DIRECTOR <b>John J. Gowan &amp; Son Inc.</b>	

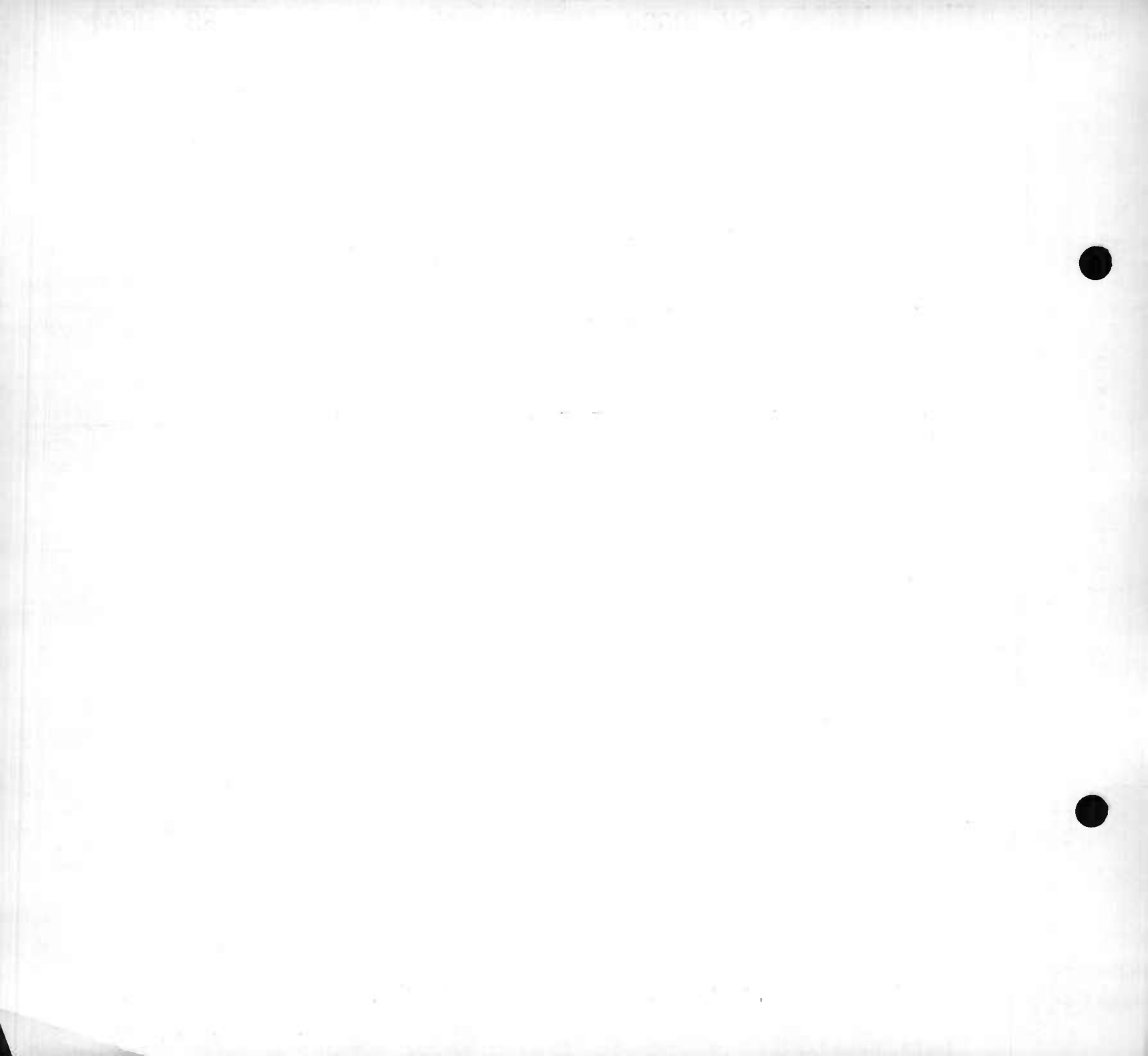




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
69 0604				69 0604	
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Joseph Ingui</u>		2. DATE AND HOUR OF DEATH <u>1-15-69</u> <u>1:15</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE FROM UNCEAED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Baltimore Co.</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>37 Mercy</u>			C. CITY OR TOWN <u>Lutherville</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <u>103 Welford Rd.</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-27-15</u>	9. AGE (In years last birthday) <u>53</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fruit Business</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Retail Merchant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>Jos. Ingui Sr.</u>			
14. MOTHER'S MAIDEN NAME <u>Jennie De Bell</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>			
16. SOCIAL SECURITY NO. <u>220-03-2227</u>		17. INFORMANT <u>Family records</u>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Brain tumor</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2-3-69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Jazayery</u>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>JAZAYERY</u>	
23D. ADDRESS <u>Mercy Hospital</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>Jan. 18, 1969</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Memorial Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Cockeysville, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1969</u>		25B. NAME OF REGISTRAR <u>R. E. Johnson</u>		25C. FUNERAL DIRECTOR <u>John Burns &amp; Sons, Towson, Maryland</u>	



Body released by Medical Examiner

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-260		69 0605		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 0605	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>GEORGE FRED WACKER</b>			
2. DATE AND HOUR OF DEATH <b>JAN. 17, 1969 3:56 P. M.</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>26-09</b>				5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>31 BALT. CITY HOSPITAL</b> <b>4840 Eastern Ave Baltimore, Md.</b>			
6. CITY OR TOWN <b>Baltimore</b>				7. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
8. STREET AND NUMBER <b>3507 Bank Street</b>				9. AGE (In years lost birthday) <b>4-1-1894 74</b>			
10. SEX <b>Male</b>				11. RACE <b>White</b>			
12. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				13. DATE OF BIRTH <b>4-1-1894</b>			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TAVERN OWNER</b>				15. KIND OF BUSINESS OR INDUSTRY <b>TAVERN</b>			
16. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				17. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
18. FATHER'S NAME <b>HERMAN WACKER</b>				19. MOTHER'S MAIDEN NAME <b>JENNIE BALK</b>			
20. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				21. SOCIAL SECURITY NO.			
22. INFORMANT <b>BCH Records: 4940 Eastern Ave Baltimore, Maryland #21224</b>				23. ADDRESS			
24. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>410.9 I</b> <b>CARDIAC ARREST</b>				25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MINS.</b>			
26. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>3 MASSIVE MI</b> <b>ASCVD</b>				27. DUE TO, OR AS A CONSEQUENCE OF: <b>1 Hour</b>			
28. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				29. MEDICAL CERTIFICATION			
30. DATE OF OPERATION				31. CONDITION FOR WHICH OPERATION WAS PERFORMED			
32. AUTOPSY? (Yes or No) <b>No</b>				33. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
34. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				35. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
36. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				37. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
38. HOW DID INJURY OCCUR?				39. I certify that (I) (this hospital) attended the deceased from <b>JAN. 17 19 69</b> to <b>JAN. 17 19 69</b> , that (I) (we) lost saw the deceased alive on <b>JAN. 17 19 69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
40. SIGNATURE <b>Joseph Kaplan M. D.</b>				41. DATE SIGNED <b>JAN. 17, 1969</b>			
42. PHYSICIAN'S NAME (Type) <b>Joseph Kaplan M. D.</b>				43. ADDRESS <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave Baltimore, Md. #21224</b>			
44. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>				45. DATE <b>1-20-69</b>			
46. NAME OF CEMETERY or CREMATORY <b>OAK LAWN Cem.</b>				47. LOCATION (City, town, or county) (State) <b>BALTO., Md.</b>			
48. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>				49. NAME OF REGISTRAR <b>Robert G. Taylor</b>			
50. FUNERAL DIRECTOR <b>Hoffman Funeral Home - 3218 Jackson St.</b>				51. ADDRESS			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0606

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 0606

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

George Clark

2. DATE AND HOUR OF DEATH

1-16-69 7:50 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

72 SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

MARYLAND

27-88

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

5833 DENMORE AVENUE

5. SEX

M

6. RACE

NEGRO

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

3/22/1896

9. AGE (In years last birthday)

72

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

OWINGS MILLS, MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

FRANK CLARK

14. MOTHER'S MAIDEN NAME

JANE ELIZABETH DOOMAN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

218-32-8953

17. INFORMANT

ADDRESS

VIRGINIA JOHNSON 3210 NORMOUNT AVE.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ASCVD

(B) ?

DUE TO, OR AS A CONSEQUENCE OF:

Pneumonia

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

aortic aneurysm

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-23 1968 to 1-16 1969 that (I) (we) last saw the deceased alive on 1-16-19-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M. Stenroos

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1/16/69

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

Sinai Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

1/20/69

24C. NAME OF CEMETERY or CREMATORY

MT. PLEASANT CEMETERY

24D. LOCATION

(City, town, or county)

(State)

OWINGS MILLS, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

JAN 20 1969

25B. NAME OF REGISTRAR

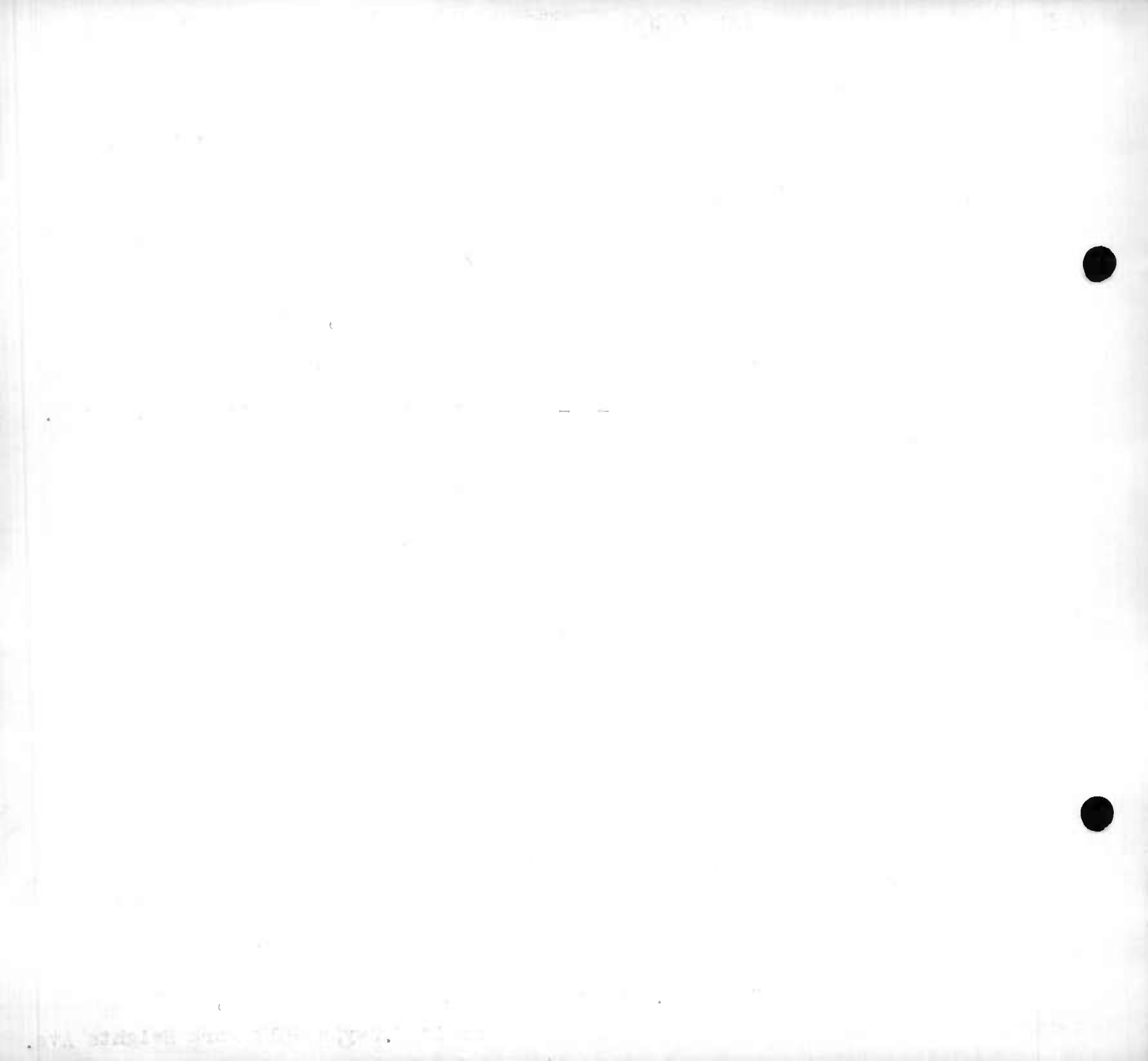
Robert E. Johnson

25C. FUNERAL DIRECTOR

Lewis T. Gwyn

ADDRESS

4517 Park Heights Ave.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 69 0607 CERTIFICATE OF DEATH

REG. NO. 69 0607

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MARGARET THERESA CARROLL</b>		2. DATE AND HOUR OF DEATH <b>JANUARY 17, 1969 3:50P M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>25-82</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>40 ST AGNES HOSPITAL</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>1811 MORRELL PARK AVE.</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>02 05 04</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED Operator</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>C &amp; P Telephone Co.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			13. FATHER'S NAME <b>DANIEL SWEENEY</b>		
14. MOTHER'S MAIDEN NAME <b>Theresa O'Brien</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <b>212051957</b>			17. INFORMANT <b>ST AGNES HOSPITAL RECORDS</b>		
18. <b>412.41+199.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CARDIOGENIC SHOCK</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ARTERIO-SCLEROTIC C-V DISEASE</b> <b>PROBABLE CARCINOMA, LIVER OR BOWEL</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 HOURS</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>JAN. 11 19 69</b> to <b>JAN. 17 19 69</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>JAN. 17 19 69</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>James G. Kane</b>				23B. DATE SIGNED <b>1/17/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>JAMES G. KANE</b>				23D. ADDRESS <b>ST AGNES HOSP. CATON &amp; WILKENS AVE</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-21-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		24E. LOCATION (Hotel)			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>	





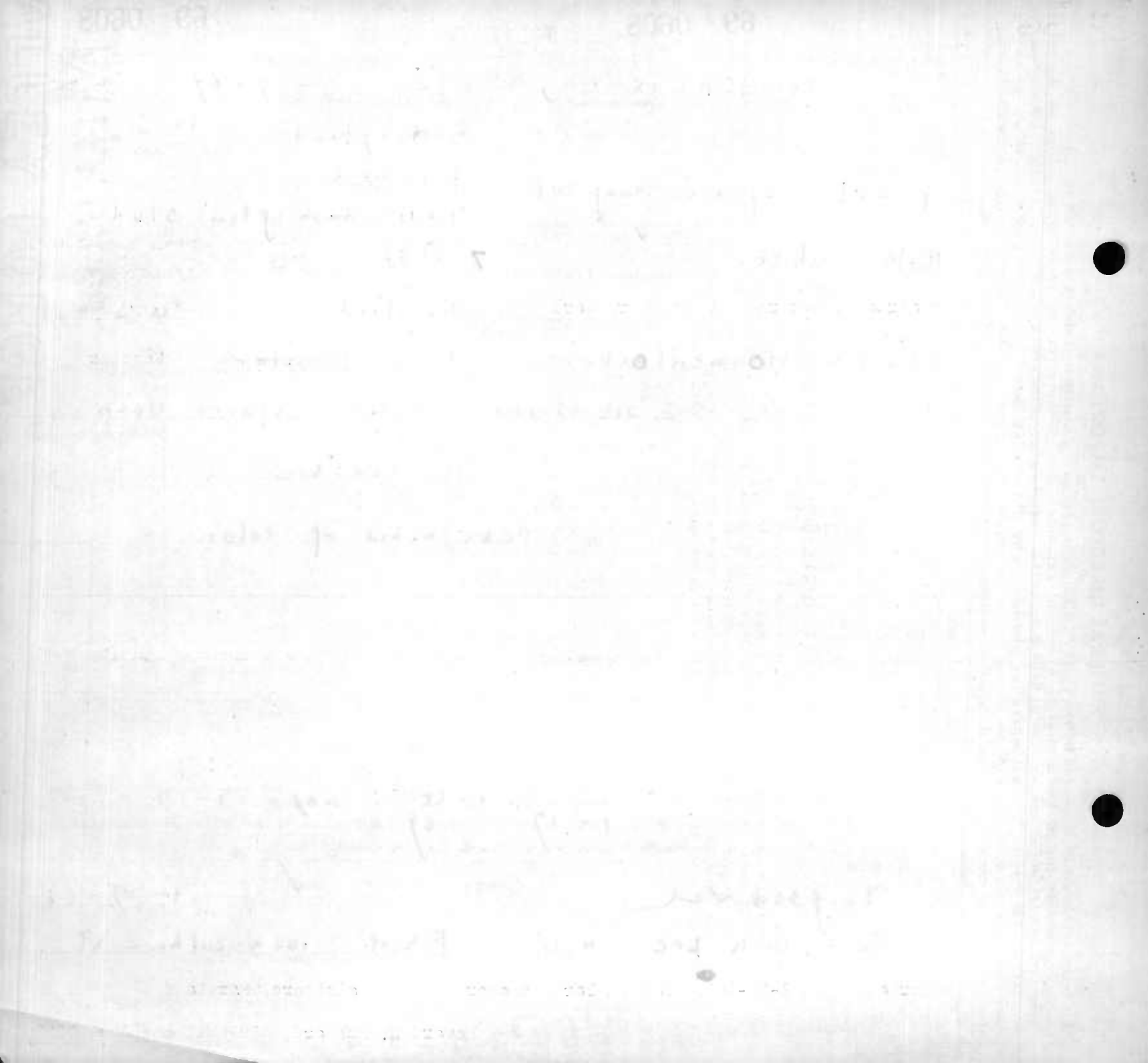
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0608 BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 69 0608

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		H. 2. DATE AND HOUR OF DEATH	
		HAMMERBACKER, George		1-17-69 4:45 A.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE		B. COUNTY
36 Franklin Square Hospital			Maryland		21-02
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			1211 Washington Blvd		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. Under 1 Yr. Months Days
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7-1-98	70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Repairman, Retired		Montgomery Ward		Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Charles Hammerbacher			Anna Kestler		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		215-69-2301		Franklin Square Hosp	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
			Cachexia		
			(B) Carcinoma of colon		
			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1-15-1969 to 1-17-1969, that (I) (we) last saw the deceased alive on 1-17-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
George Sochocki				1-17-69	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Sung Book Lee - M.D.		F.S.H. 1001 Calhoun St			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		1-20-1969		Loudon Park Cemetery	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 20 1969		Robert E. Johnson		Howard H. Hubbard, 4107 Wilkens Ave, 21229	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0609 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 69 0609

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Snyder, Stanley A.</u>		2. DATE AND HOUR OF DEATH <u>1/17/69 4:30 P.</u>	
3. PLACE IN BALTIMORE/ MARYLAND, WHERE PRONOUNCED DEAD <u>Univ. of Maryland Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Washington</u>		C. CITY OR TOWN <u>Morrell Park</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Univ. of Maryland Hospital</u>		E. STREET AND NUMBER <u>2615 Washington Blvd.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-24-04</u>	9. AGE (In years last birthday) <u>64</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steelworker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Industry</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland NEW YORK</u>	
13. FATHER'S NAME <u>STANLEY SNYDER -</u>		14. MOTHER'S MAIDEN NAME <u>ANNA GRZEGORZEWSKI</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-10-4769</u>		17. INFORMANT <u>Mrs. Edna A. Snyder, 2615 Washington Blvd.</u>	
18. <u>450X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Pulmonary Embolism</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>17 Jan 1969</u> to <u>17 Jan 1969</u> that (I) (we) last saw the deceased alive on <u>17 JAN 1969</u> and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dale P. Baker M.D.</u>				23B. DATE SIGNED <u>17 JAN. 69</u>	
23C. PHYSICIAN'S NAME (Type) <u>DALE P. BAKER M.D.</u>		23D. ADDRESS <u>University Hospital Balt. Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-21-1969</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Sullivan</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0610		BALTIMORE CITY HEALTH DEPARTMENT		69 0610	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>Waldeck, Jerome B.</u>		2. DATE AND HOUR OF DEATH <u>1/16/69</u> <u>9:30 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>25 Sinai Hosp. of Balt.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland.</u> B. COUNTY <u>28-64</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>25 Sinai Hosp. of Balt.</u>		C. CITY OR TOWN <u>Balt.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>		6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Iron Worker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Carnegie Steel Co.</u>		8. DATE OF BIRTH <u>7/9/86</u>	
13. FATHER'S NAME <u>John Joseph Waldeck</u>		14. MOTHER'S MAIDEN NAME <u>Mary Amelia Heinekemp</u>		9. AGE (in years last birthday) <u>82</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-03-1181</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
17. INFORMANT <u>Mrs. Anna B. Waldeck, 7 N. Beechfield Ave.</u>		ADDRESS <u>21229</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
18. <u>486X+1230.9</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Respiratory Arrest</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Breunonia</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Diabetes Mellitus</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>1/16/69</u> 19 to <u>1/16/69</u> 19 that (1) (we) last saw the deceased alive on <u>1/16/69</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>K. L. Goodman, M.D.</u>		23B. DATE SIGNED <u>1/16/69</u>		23C. PHYSICIAN'S NAME (Type) <u>K. L. Goodman, M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-20-1969</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard</u>	
24D. LOCATION <u>Woodlawn, Maryland</u>		ADDRESS <u>4107 Wilkens Ave. 21229</u>			

0-00 28

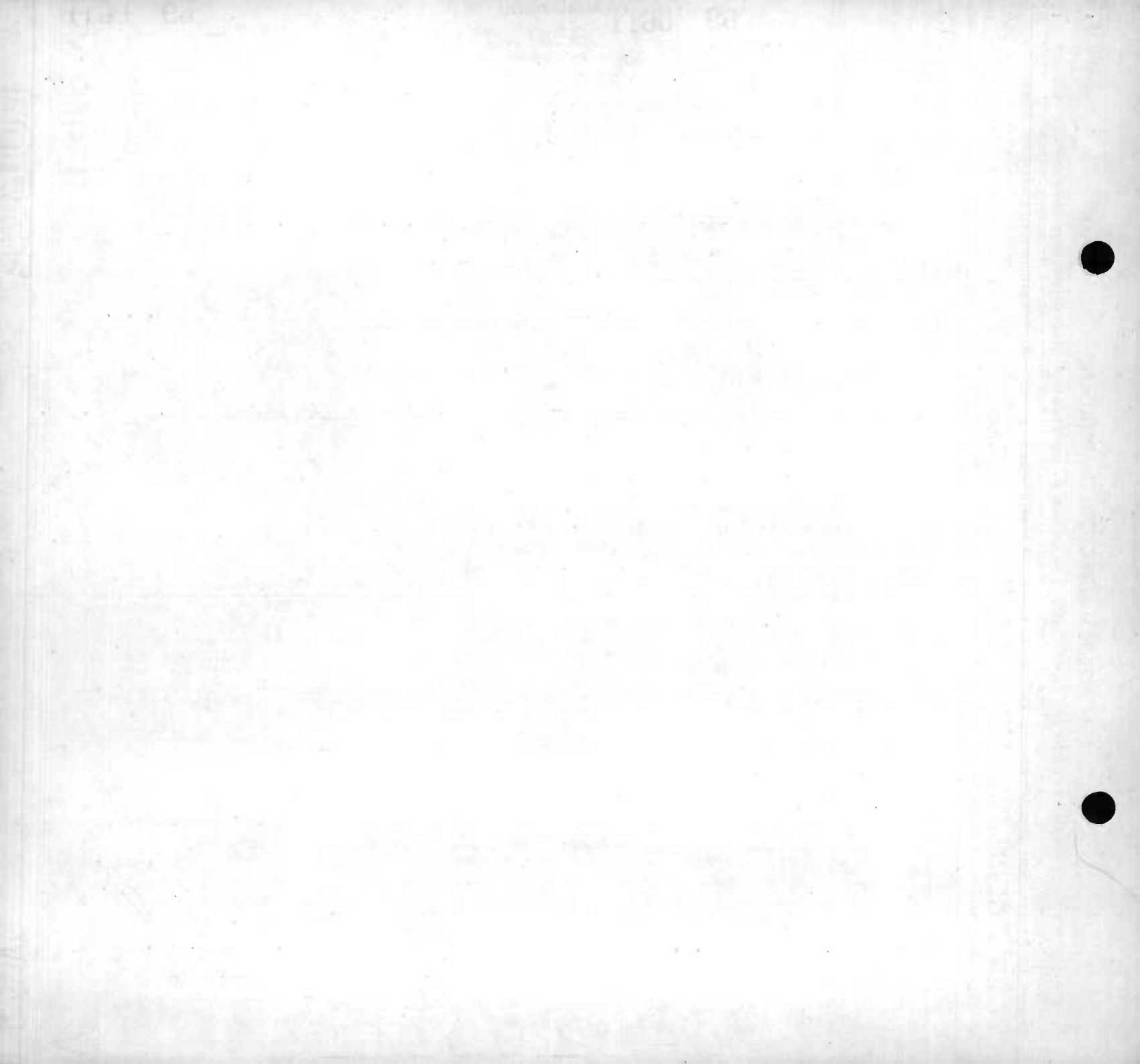
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## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Clyde W. Williams</i>		2. DATE AND HOUR OF DEATH <i>1/17/69 11:30 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>20-04</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>BALTIMORE CITY HOSPITALS</i> <i>4940 EASTERN AVENUE</i> <i>BALTIMORE, MARYLAND 21224</i>				C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>MALE</i>		6. RACE <i>NEGRO</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Shoemaker</i>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <i>6-25-08</i> 9. AGE (In years lost birthday) <i>60</i>	
11. BIRTHPLACE (State or foreign country) <i>MARYLAND N Carolina</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Tyrone Williams</i>				14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>245-28-6060</i>		17. INFORMANT <i>BCH: RECORDS 4940 EASTERN AVE. BALTO. MD.</i> ADDRESS <i>21224</i>	
18. <i>436.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Chronic Bronchitis</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>CVA</i>	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>7 months</i> <i>7 months</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <i>(this hospital)</i> attended the deceased from <i>1/8</i> 19 <i>69</i> to <i>1/17</i> 19 <i>69</i> , that (I) <i>(we)</i> last saw the deceased alive on <i>1/17</i> 19 <i>69</i> and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(We)</i> <i>(did)</i> (did not) view the body after death.					
23A. SIGNATURE <i>Robert H. Brook</i> DEGREE				23B. DATE SIGNED <i>1/17/69</i> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <i>ROBERT H. BROOK M.D.</i> DEGREE				23D. ADDRESS <i>BALTIMORE CITY HOSPITALS</i> <i>4940 EASTERN AVE. BALTO. MD. 21224</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/21/69</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt Auburn Cemetery</i>	
24D. LOCATION <i>Baltimore Md</i>		24E. NAME OF CEMETERY OR CREMATORY		24F. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 20 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Stegman</i>		25C. FUNERAL HOME <i>Halstead</i> ADDRESS <i>1206 W North Ave</i>	

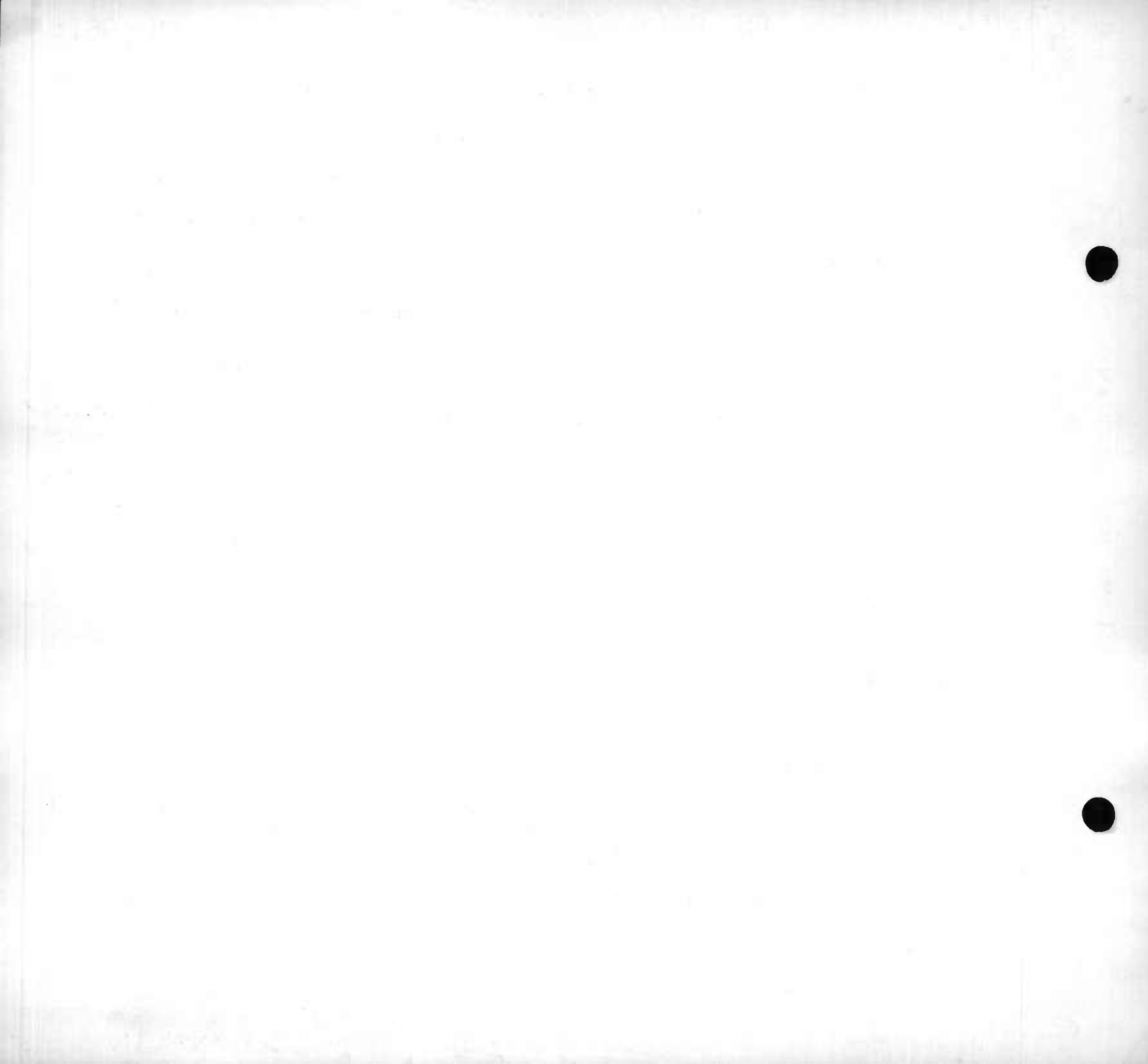




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0612		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 0612	
BIRTH NO. 69-00382		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <u>Carlin Alice Gaines</u>		2. DATE AND HOUR OF DEATH <u>1-17-69</u> <u>9:10</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University at Maryland</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>2102 W. Franklin St. #23</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-5-69</u>	9. AGE (In years last birthday) <u>12</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Neighborhood</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Neighborhood</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Roland Gaines</u>			
14. MOTHER'S MAIDEN NAME <u>Margaret Webb</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Neighborhood</u>			
16. SOCIAL SECURITY NO. <u>N/A</u>		17. INFORMANT <u>GARY A. FLEAING, M.D. UNIV. of Maryland</u>			
18. <u>746.91</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CONGESTIVE HEART DISEASE</u>		<u>12 days</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Pneumonia, Broncho-</u>		<u>3 days</u>	
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Hypertension</u>				<u>3 days</u>	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1-13</u> 19 <u>69</u> to <u>1-17</u> 19 <u>69</u> and that (I) (we) last saw the deceased alive on <u>1-17</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>GARY A. FLEAING, M.D.</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1-17-69</u>	
23C. PHYSICIAN'S NAME (Type) <u>GARY A. FLEAING, M.D.</u>		23D. ADDRESS <u>UNIV. of Maryland Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>1/21/69</u>	24C. NAME of CEMETERY or CREMATORY <u>Mt Auburn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
25A. DATE RECEIVED BY HEALTH DEPT. <u>JAN 20 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>Halstead</u> ADDRESS <u>1206 W North Ave</u>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ESTHER RICE

2. DATE  
OF  
DEATHKnown ☐ Estimated ☒

Month

Day

Year

Hour

1

18

69

641 A.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

J. Hopkins Hosp. (DOA)

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

1

18

69

641 A.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

10-01

6. SEX

F

7. RACE

C

B. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

2/17/05

10. AGE (In years last birthday)

63

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

1109 ENSOR ST

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF  
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Randolph Thomas

14A. USUAL OCCUPATION (Give kind at work done during most of working life, even if retired)

Domestic

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Georgia

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Mrs Gladys Hayes, 1109 Ensor St

19. 199.0 I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Carcinomatosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Werner H. Spitz M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1.18.69

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1/22/69

24C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.

JAN 20 1969

25B. NAME OF REGISTRAR

R. L. E. F. Jones

25C. FUNERAL DIRECTOR

A. Halstead

ADDRESS

1206 W North Ave

stan. ea

stan. ea

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

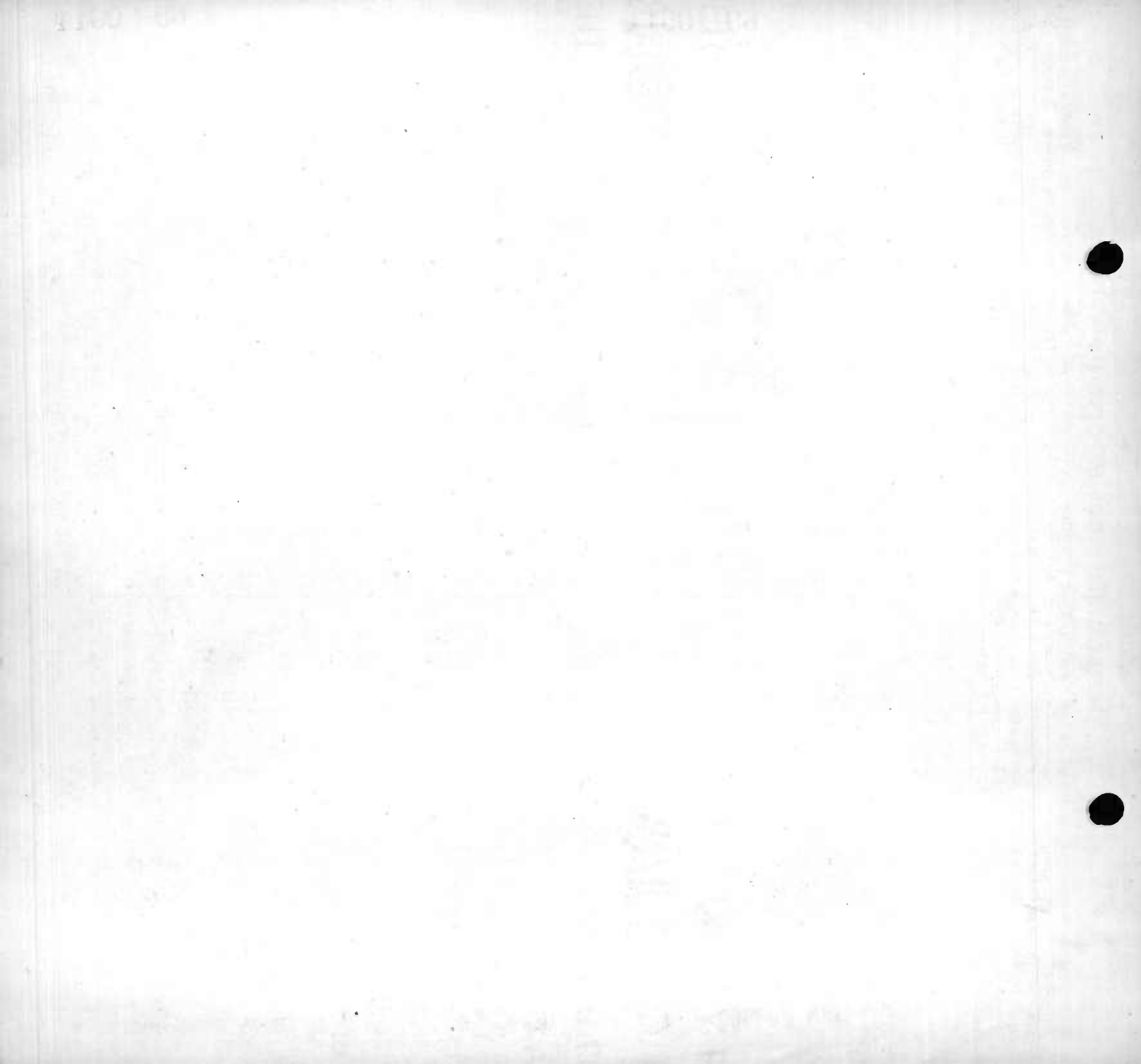
69 0614

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

69 0614

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Robert BOWSER</i>		2. DATE AND HOUR OF DEATH <i>1-12-69</i>   <i>9:20 A</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>HARFORD</i> Co. <i>62-00</i>		C. CITY OR TOWN <i>Perryman</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>George Washington Nurs. Home</i> <i>90</i>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		E. STREET AND NUMBER	
5. SEX <i>MALE</i>	6. RACE <i>NEGRO</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-5-1890</i>	9. AGE (In years lost birthday) <i>78</i>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MD.</i>	
13. FATHER'S NAME <i>Robert BOWSER</i>		14. MOTHER'S MAIDEN NAME <i>Harriett Crisie</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>218-07-3100</i>		17. INFORMANT <i>Chart # 782 607 Penn Ave.</i>	
18. <i>204.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <i>Acute Myocardial Infarction</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Lymphoid leukemia - Chronic</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Chronic Cardiac Insufficiency</i> (C) <i>Unknown</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		<i>Rt. Inguinal Hernia</i>		<i>Unknown</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>4/5</i> <i>1966</i> to <i>1/12</i> <i>1969</i> , that (I) (we) last saw the deceased alive on <i>1/3</i> <i>1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>E. E. Holt M.D.</i>				23B. DATE SIGNED <i>1/14/69</i>	
23C. PHYSICIAN'S NAME (Type) <i>E. E. Holt, M.D.</i>				23D. ADDRESS <i>3715 Liberty Hts. Ave.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/19/69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt Calvary Cemetery</i>	
24D. LOCATION <i>A A County Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 20 1969</i>			
25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR <i>A. HALSTEAD</i>			
25D. ADDRESS <i>1206 W North Ave</i>					



69 0615 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO.

69 0615

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>or Yudkevich</b> <b>Latiana or PAULINE EUTKIEWITCH - Yutkiewicz</b>		2. DATE AND HOUR OF DEATH <b>1-17-69</b> <b>2.30 A M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE COUNTY</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 THE JOHNS HOPKINS HOSPITAL</b>		E. STREET AND NUMBER <b>29 N. ANN STREET</b>		21231	
5. SEX <i>Female</i> <b>WHITE</b>	6. RACE <i>white</i> <b>FEMALE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-22-90</b>	9. AGE (In years last birthday) <b>78</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <b>Russia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>1st Papers</b>		13. FATHER'S NAME <b>UNK</b>		14. MOTHER'S MAIDEN NAME <b>UNK</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-12-8098</b>		17. INFORMANT <b>Nancy Nechay 29 N Ann Stret Balto Md 2</b>	
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary embolus</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>3 days</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Ch. obstruct. pul. dis. ASVD</b>		19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NO</b>	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		(If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>Jan 12, 1969</b> to <b>Jan 17, 1969</b> that (1) (we) last saw the deceased alive on <b>Jan 16, 1969</b> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (No) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Leonard Rossy, Jr. M.D.</b>		23B. DATE SIGNED <b>1-17-69</b>		23C. PHYSICIAN'S NAME (Type) <b>LEONARD ROSSOFF JR.</b>	
23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>JAN 20 1969</b>	
24C. NAME OF CEMETERY or CREMATORY <b>ST ANDREW'S CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>GERMAN HILL RD BALTO MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>	
25B. NAME OF REGISTRAR <b>20258 J. J. J.</b>		25C. FUNERAL DIRECTOR <b>THE DIPPEL BROS INC 1800 E LOMBARO ST</b>		ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1880

Johnston & Co.

Ch. Johnston & Co. 1880

Ch. Johnston & Co. 1880



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0616		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 0616	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Mr. Peter Joseph Palughi</b>		2. DATE AND HOUR OF DEATH <b>1-17-69 10-45 A M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>3-02</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>35 Church Home &amp; Hosp. Baltimore Md.</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>809 Stiles St. 21202</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-11-06</b>	9. AGE (In years last birthday) <b>62</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>Joseph Palughi</b>		14. MOTHER'S MAIDEN NAME <b>Louise Freske</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-05-3335</b>		17. INFORMANT <b>Grace Palughi Wife 809 Stiles St</b>	
18. <b>491X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Peri-plural Circulatory failure Pulmonary oedema</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Chronic Bronchitis Emphysema</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerosis</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerosis</b>			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>1-14-69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ac. Respiratory Distress</b>		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from <b>1-13-1969</b> to <b>1-17-1969</b> , that (1) (we) last saw the deceased alive on <b>1-17-1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>J. Nidiry M.D.</b>		23B. DATE SIGNED <b>1-17-1969</b>		23C. PHYSICIAN'S NAME (Type) <b>JOSEPH NIDIRY M.D.</b>	
23D. ADDRESS <b>CHURCH HOME Hospital Baltimore</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>JAN 21 1969</b>	
24C. NAME of CEMETERY or CREMATORY <b>HOLY REDEEMER CEM</b>		24D. LOCATION (City, town, or county) (State) <b>4430 BELAIR RD BALTO MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>	
25B. NAME OF REGISTRAR <b>Robert E. Stokely</b>		25C. FUNERAL DIRECTOR <b>THE DIANE BROS INC 1800 ELMHURST ST</b>		25D. ADDRESS	

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 0617

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES MC CORMICK SR.

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

January 15, 1969

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

January 15, 1969

4:20 P.M.

5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

7. RACE

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Male

White

Baltimore

YES ☒ NO ☐

9. DATE OF BIRTH

10. AGE (In years  
last birthday)If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

APRIL 13 1919

49

2266 Brookfield Avenue

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

BALTIMORE MD

USA.

JOHN PATRICK MCCORMICK

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

PAINTER

MARY ROHELDER

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

YES

WORLD WAR II

212-12-7379

CHARLES P MCCORMICK JR 1038 FOX RIDGE LANE

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Lobar pneumonia  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Yes

22D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL

SIGNATURE

M.D.

EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

January 16, 1969

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

BURIAL

JAN 20 1969

BALTIMORE NATIONAL

301 FREDERICK RD BALTO MD

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JAN 20 1969

Robert E. Fairbairn

THE DIPPEL BROS INC 1800 E LOMBARD ST

THE UNITED STATES OF AMERICA

STATE OF NEW YORK  
IN SENATE  
JANUARY 10, 1910  
REPORT  
OF THE  
COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 10, 1899

ALBANY: J.B. LEECH, STATE PRINTER, 1910.

THE STATE OF NEW YORK  
IN SENATE  
JANUARY 10, 1910  
REPORT  
OF THE  
COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 10, 1899

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 69 0618	
<div>69-09315 69 0618</div> <div>131 87 36</div> <div>CERTIFICATE OF DEATH</div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BOWLIN, BABY BOY-ROBERT LEE		1/16/69 9:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
33 THE JOHNS HOPKINS HOSPITAL			MARYLAND BALTIMORE CITY		
			C. CITY OR TOWN D. INSIDE CITY LIMITS?		
			BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER		
			2100 E. FAIRMOUNT AVE 21213		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1-14-69	----	2
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
CHILD		---		BALTIMORE MD	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
MICHAEL BOWLIN			GLORIA GRIFFEN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		NONE		MICHAEL BOWLIN 2100 E FAIRMOUNT AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			HYPOVOLEMIC SHOCK		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) PNEUMOMEDIASTINUM		
			(C) HYALINE MEMBRANE DISEASE		
II			- NONE		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2 NONE		NONE		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
NO		HOSP.		NONE	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
NONE		While At Work <input type="checkbox"/> - Not While At Work <input type="checkbox"/>		NONE	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from 1/14 1969 to 1/16/69 that (I) ( <del>last</del> ) last saw the deceased alive on 1/16 1969 and that in (my) ( <del>last</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Kenton R. Holden, M.D.				1/16/69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
KENTON R. HOLDEN				JOHNS HOPKINS HOSP. - PREMIE NURS.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL JAN 18 69				MT CARMEL CEM.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 18 1969		Robert E. Taniguchi		DIPPEL BROS INC 1800 E LOMBARD ST	

Johns Hopkins Hosp. - Baltimore

Kent E. Hodges, M.D.

1/14/11  
1/16/11  
1/16/11

none  
none  
none  
none  
none  
none

- none

HYALINE MEMBRANE DISEASE  
PNEUMOMEDISTINUM

HYPOTENSIVE SHOCK

10 ml  
10 ml

Bowling, Earl Roy  
1/16/11

1/16/11



R-100

69 0619 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 0619

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JOHN C. RUBY Sr.</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>January 15, 1969</b>		Hour M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>January 15, 1969</b>		Hour <b>6:15 P.</b>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>12-02</b>		
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>
9. DATE OF BIRTH <b>July 3, 1908</b>		10. AGE (In years lost birth day) <b>60</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?		E. STREET AND NUMBER <b>2906 St. Paul Street</b>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>?</b>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW1</b>		17. SOCIAL SECURITY NO. <b>220-05-1198</b>		18. INFORMANT <b>John Ruby Jr. Phenox Md.</b>
19. <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
20A. DATE OF OPERATION <b>6</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>No</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> <b>January 16, 1969</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/20/69</b>		24C. NAME of CEMETERY or CREMATORY <b>National</b>
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>Paul E. Chenoweth Jr.</b>
				ADDRESS <b>3617 Chestnut Ave.</b>

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WALTER P. BOYD

0100 03



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

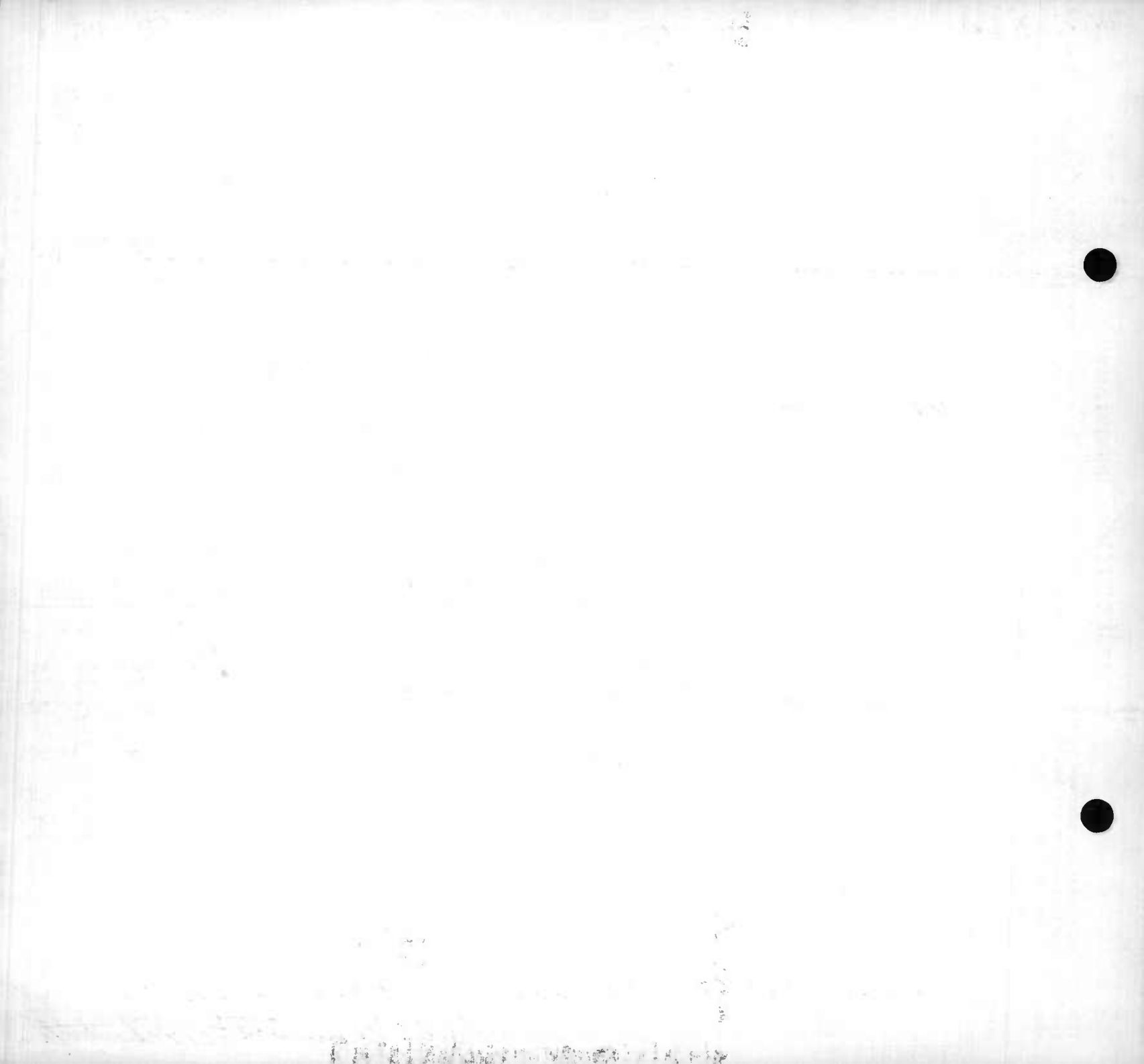
# BALTIMORE CITY HEALTH DEPARTMENT

## 69 0620 CERTIFICATE OF DEATH

REG. NO.

69 0620

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Julia Mitzel</u>		2. DATE AND HOUR OF DEATH <u>1-14-69</u> <u>9:10 a.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University of Maryland Hosp.</u>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>13-07</u>		
5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			E. STREET AND NUMBER <u>1105 W. 42nd St.</u>		
10B. KIND OF BUSINESS OR INDUSTRY			8. DATE OF BIRTH <u>11-14-91</u> 9. AGE (In years lost birthday) <u>77</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>
13. FATHER'S NAME <u>Morgan A. Allen</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			14. MOTHER'S MAIDEN NAME <u>Jane Tracy</u>		
16. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS
18. <u>205-01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH <u>High Output Cardiac Failure</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Anemia</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Acute myelogenous leukemia</u> (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u> <u>2 wk.</u> <u>6 mo.</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <u>1-13</u> 19 <u>69</u> to <u>1-14</u> 19 <u>69</u> that (X) (we) last saw the deceased alive on <u>1-14</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Paul E. Charney</u>			23B. DATE SIGNED <u>1-14-69</u>		
23C. PHYSICIAN'S NAME (Type) <u>Paul E. Charney</u>			23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1/17/69</u>		24C. NAME OF CEMETERY or CREMATORY <u>JESSUPS</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTO. CO. MD.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1969</u>		25B. NAME OF REGISTRAR <u>Paul E. Charney</u>		25C. FUNERAL DIRECTOR <u>Paul E. Charney</u> ADDRESS <u>3607 Chestnut St.</u>	



# FUNERAL DIRECTOR: IMPORTANT

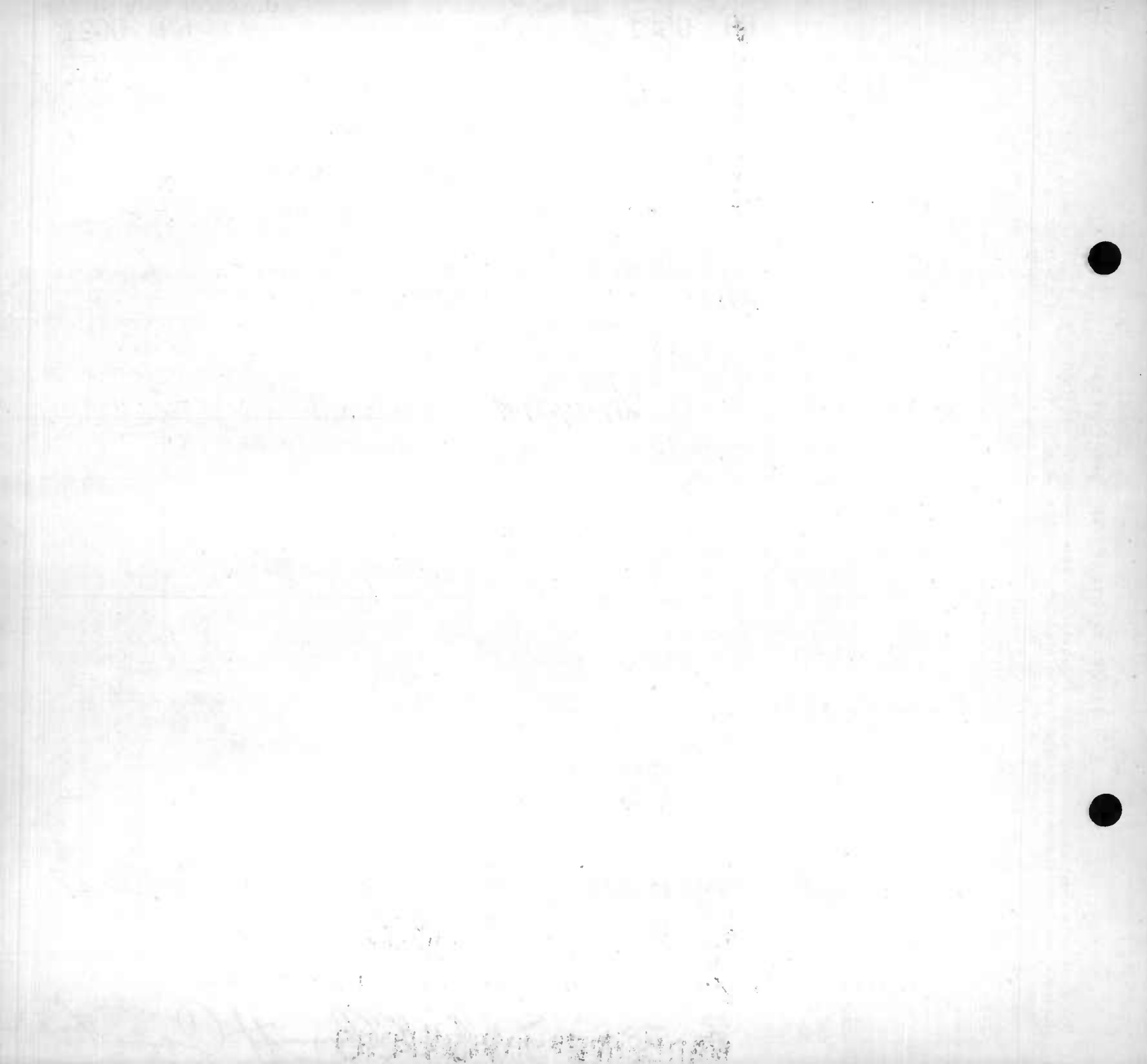
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## 69 0621 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 69 0621

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>HARRY T. HARRIS</u>		2. DATE AND HOUR OF DEATH <u>1-15-69</u> <u>2:45 P.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>26-31</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>19 NORTH CHARLES GEN HOSP</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>5820 PLUMER AVE #6</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1-21-1897</u>	9. AGE (In years lost birthday) <u>72</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>HARRIS, EUGENE</u>		14. MOTHER'S MAIDEN NAME <u>ELLA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>WWI YES</u>		16. SOCIAL SECURITY NO. <u>217-89-5747</u>		17. INFORMANT <u>CHART - NORTH CHARLES Hosp</u>	
18. <u>410.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <u>Acute pulmonary edema</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute myocardial infarct</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Coronary artery atherosclerosis</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary artery atherosclerosis</u>			
(C) DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary artery atherosclerosis</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>1/14</u> <u>1969</u> to <u>1/15</u> <u>1969</u> , that (I) (we) lost saw the deceased alive on <u>1/15</u> <u>1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Edward Sherrer, Jr M.D.</u> OEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>16 Jan 69</u>	
23C. PHYSICIAN'S NAME (Type) <u>Edward Sherrer, Jr M.D.</u> DEGREE		23D. ADDRESS <u>N. Char. Gen Hosp.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1/18/69</u>		24C. NAME OF CEMETERY or CREMATORY <u>LOMAINE PARK</u>	
24D. LOCATION (City, town, or county) <u>BALTO. MD.</u>		24E. STATE <u>MD.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>James K. Kuntz</u> ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

69 0622

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Beverly Ann Russell

2. DATE AND HOUR OF DEATH

January 16 1969 3:30 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Univ of Md Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Ohio

V-32

C. CITY OR TOWN

Steubenville

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

134 Jackson Drive

43952

Ohio

5. SEX

F

6. RACE

Caucasian

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

5-23-44

9. AGE (In years last birthday)

24

10. Under 1 Yr. Months Days

11. Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

H/W

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Oklahoma

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William H. Davis

14. MOTHER'S MAIDEN NAME

Pauline Treat

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

no

no

16. SOCIAL SECURITY NO.

219-48-5742

17. INFORMANT

Steubenville, Ohio ADDRESS

Mr John Russell 134 Jackson Drive

18. 563.01

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Severe regional

enteritis = fecal

fistula + severe wasting

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

10 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

I+D (12-21-69)

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

fecal fistula

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 12-2-1968 to 1-16-1969 that (1) (we) last saw the deceased alive on 1-16-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Stanley Silber, M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1-16-69

23C. PHYSICIAN'S NAME (Type)

Stanley Silber, M.D.

23D. ADDRESS

Univ of Md Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

1-20-69

24C. NAME OF CEMETERY or CREMATORY

Meadowridge Cemetery

24D. LOCATION

Baltimore

(City, town, or county)

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 20 1969

25B. NAME OF REGISTRAR

Robert E. Stanley

25C. FUNERAL DIRECTOR

Lassahn Funeral Home 7401 Belair Road 36

ADDRESS

1000

1000

1000

1000

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>HYMAN, WILLIAM A.</b>		2. DATE AND HOUR OF DEATH <b>1.15.1969 9.0 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore Co.</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>CHURCH HOME &amp; HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>100N Broadway Baltimore.</b>		C. CITY OR TOWN <b>Middle River 21220</b>	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <b>2012 Oakland Road (20)</b>	
5. SEX <b>male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-16-88</b>	9. AGE (In years last birthday) <b>80 yrs.</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Paint Machine Operator</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Fischer Body Co.</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Marcus Hyman</b>		14. MOTHER'S MAIDEN NAME <b>Eyrtie Scherrba</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216 10 2204</b>		17. INFORMANT <b>William Hyman</b>	
18. <b>410.9 I</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute Myocardial Infarction</b>		<b>days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Arteriosclerosis</b>		<b>years</b>	
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>1-11</b> 19 <b>69</b> to <b>1-15</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>1-15</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Jose MIER JR</b>		M.D. DEGREE		23B. DATE SIGNED <b>1-15-69</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>100 W. Broadway</b>		23E. CITY, TOWN, OR COUNTY <b>BALTIMORE MD.</b>	
23F. STATE <b>21221</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/18/69</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		24D. LOCATION <b>Baltimore Co., Md.</b>		24E. STATE <b>Md.</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>JAN 20 1969</b>		25B. NAME OF REGISTRAR <b>Robert G. Taylor</b>		25C. FUNERAL DIRECTOR <b>Brudzinski Funeral Home</b>	
25D. ADDRESS <b>1407 Eastern Ave.</b>					





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
69 0624 CERTIFICATE OF DEATH

REG. NO.

69 0624

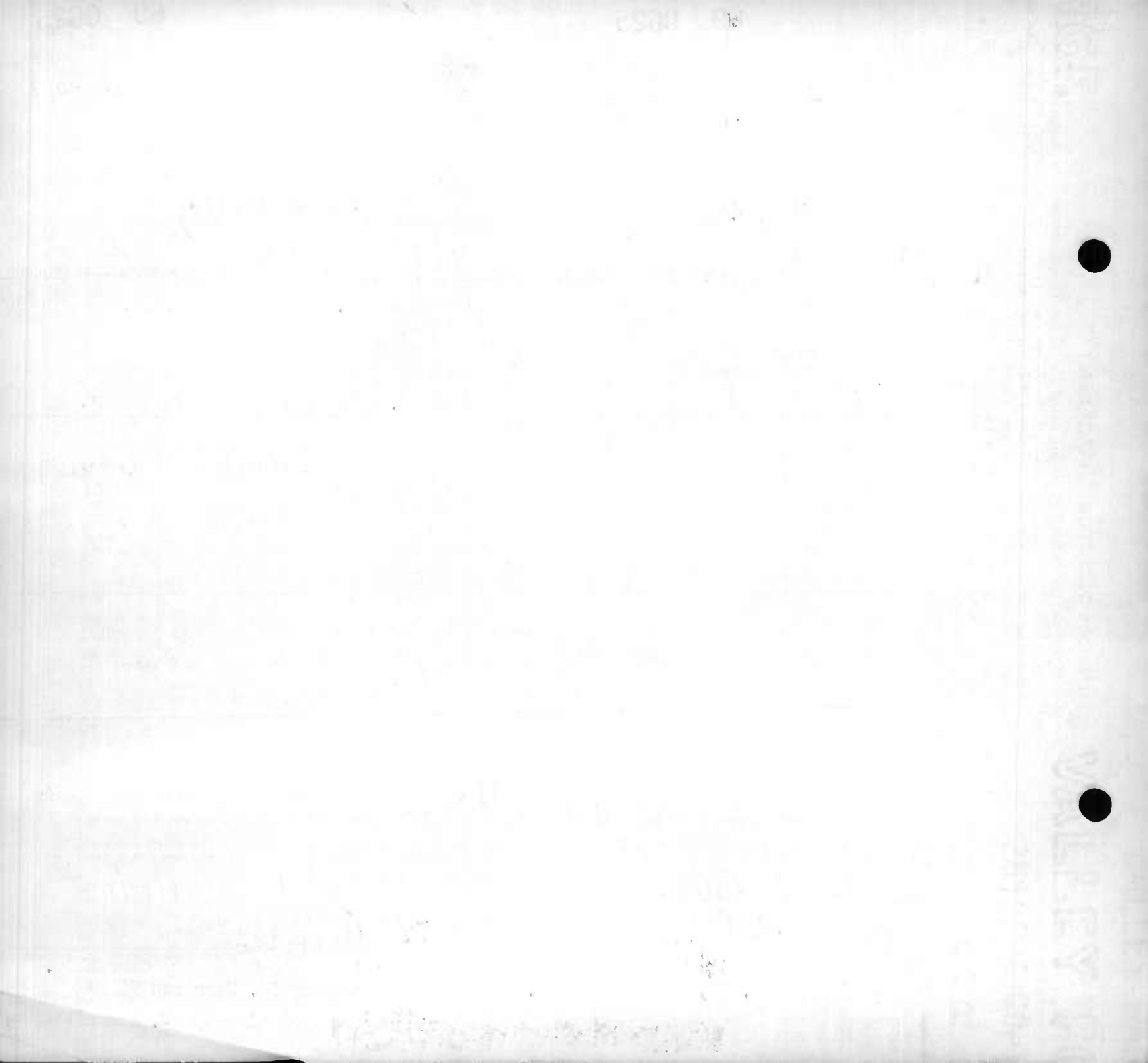
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MARY E. GORMAN</b>		2. DATE AND HOUR OF DEATH <b>January 11, 1969</b> <i>10:30 A.</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>00 204 Upnor Road Baltimore, Maryland</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>27-12</b> C. CITY OR TOWN <b>Homeland</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>204 Upnor Road</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-10-1887</b>	9. AGE (In years last birthday) <b>81</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Rufus W. Appleby</b>		14. MOTHER'S MAIDEN NAME <b>Anna V. Webb</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Charles J. Nichols, 204 Upnor Road</b>	
18. <b>370X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Acute hepatitis</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>2 wks</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>			
19. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Hypertensive A.S.C.V.D.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>19 62</b> to <b>1/11</b> 19 <b>69</b> , that (I) (we) lost saw the deceased alive on <b>1/11/69</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Francis W. Gluck</i> DEGREE				23B. DATE SIGNED <b>1/11/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Francis W. Gluck</b> DEGREE				23D. ADDRESS <b>100 W. University Parkway, Balto., Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-13-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Roseland Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Reedville, Virginia</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>			
25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. of a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0625		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 0625	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Burton Collins</u>		2. DATE AND HOUR OF DEATH <u>1/15/69</u> <u>11:40 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		5. SEX <u>M</u> 6. RACE <u>W</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>1006 Park Valley</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/16/02</u> 9. AGE (In years last birthday) <u>66</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Meat Business</u>		11. BIRTHPLACE (State or foreign country) <u>Littletown Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Harvey Martin Collins</u>		14. MOTHER'S MAIDEN NAME <u>Mable DeHoff</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>224-01-3737</u>		17. INFORMANT ADDRESS <u>James L. Collins 1006 Park Valley Ct.</u>	
18. <u>4/10/9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Renal Failure</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial Infarction</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1/19</u> 19 <u>69</u> to <u>1/15</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1/15</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Barton A. Cohen</u>				23B. DATE SIGNED <u>1/15/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>Barton A. Cohen</u>				23D. ADDRESS <u>Sinai Hospital</u>	
24A. BURIAL REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Jan. 18, 69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Lake View Ce.</u>	
24D. LOCATION (City, town, or county) (State) <u>Liberty Rd. Harrison Ville</u>		24E. FUNERAL DIRECTOR <u>Loring Myers</u>		24F. ADDRESS <u>8728 Liberty Rd. Randallstown</u>	



S-365

69 0626 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 0626

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>RICHARD STARNES</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> January 7, 1969 Hour: 7:35 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>44 Union Memorial Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour January 7, 1969 7:35 A.M.	
6. SEX male		7. RACE white	
B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH <b>June 9-24</b>		10. AGE (In years lost birthday) 44	
11. BIRTHPLACE (State or foreign country) <b>Catawba Co. NC.</b>		12. CITIZEN OF <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unk</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Unk</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Unk</b>		17. SOCIAL SECURITY NO. <b>Unk</b>	
13. FATHER'S NAME <b>Unk</b>		15. MOTHER'S MAIDEN NAME <b>Metta Starnes (Killian)</b>	
18. INFORMANT <b>Mrs. Sam Edward Killian</b>		ADDRESS <b>St 1</b>	
19. <b>E8871X</b>		CAUSE OF DEATH <b>Subdural Hemorrhage</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Unknown</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Unknown</b>		22F. HOW DID INJURY OCCUR? <b>subj. allegedly fell - striking head</b>	
22D. TIME OF INJURY (APPROX.) 12/22/68 UNK		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		DATE SIGNED <b>1/7/69</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>1/10/69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>H. Patus Luth Cem.</b>		24D. LOCATION (City, town or county) (State) <b>Catawba W. Carolina</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>	
25C. FUNERAL DIRECTOR <b>T. Fisher</b>		ADDRESS <b>1920 Eastern Ave.</b>	

N83 2.9690000625

63 0826

63 0826

Jan 7-24  
Caterpillar Co. 11/11/23  
Wm. J. H. (Killing)  
Wm. J. H. (Killing)

WALT

General 11/10/23 Wm. J. H. (Killing)  
Caterpillar Co.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-652		69 0627		BALTIMORE CITY HEALTH DEPT.		REG. NO. 69 0627	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>RHODA M. KRANKA</b>			
2. DATE AND HOUR OF DEATH <b>JAN. 15, 1969 9:30 P.M.</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION <b>31</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BALTIMORE CITY HOSPITALS 4940 Eastern Ave Baltimore, Maryland #21224</b>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>26-36</b>		C. CITY OR TOWN <b>BALTIMORE</b>	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>6318 TOONE ST. 21224</b>		5. SEX <b>Female</b>		6. RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-15-85</b>		9. AGE (In years last birthday) <b>83</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>House Work</b>		11. BIRTHPLACE (State or foreign country) <b>Uruguay</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>? Bravo</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-20-1260A</b>	
17. INFORMANT <b>BCH Records:</b>		ADDRESS <b>4940 Eastern Ave Baltimore, Maryland #21224</b>		18. CAUSE OF DEATH <b>Arteriosclerotic Heart Disease</b>			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 years</b>			
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At <input type="checkbox"/> Nat White <input type="checkbox"/> Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>JAN. 15 19 69</b> to <b>DEC. 27 19 68</b> and that (I) (we) last saw the deceased alive on <b>DEC. 27 19 68</b> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Benjamin Lechner, M.D.</b>		23B. DATE SIGNED <b>1/15/69</b>		23C. PHYSICIAN'S NAME (Type) <b>BENJAMIN LECHNER, M.D.</b>		23D. ADDRESS <b>Baltimore City Hospitals 4940 Eastern Ave Baltimore, Md. #21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-18-69.</b>		24C. NAME of CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>7225 Eastern Blvd., Ba. Co., Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Charles J. Zeiler</b>		ADDRESS <b>6224 Eastern Ave. Balto., 21224, Md.</b>	







This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

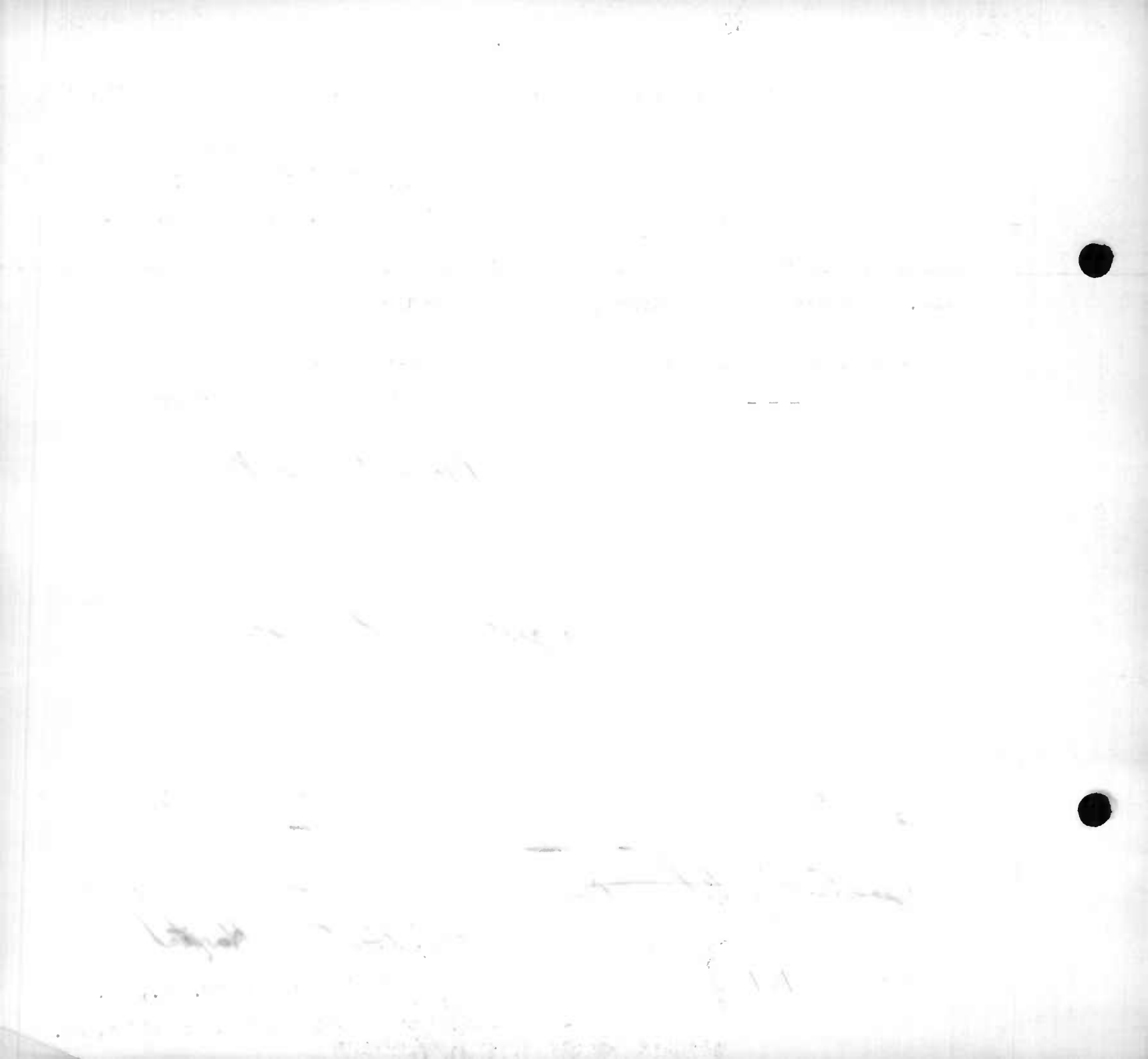
69 0628

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

69 0628

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Applegarth, Harold G.		1/15/69 11:15 AM.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				Maryland Dorchester 59-13	
The Johns Hopkins Hospital				C. CITY OR TOWN D. INSIDE CITY LIMITS? 313 Oakley St. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				313 Oakley St.. Cambridge, Md.	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11/21/89	79	Eng. & Merchant
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Eng. & Merchant		Electrical		Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
William F. Applegarth			Anette Keene		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				LeCompte Funeral Service records	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
				Monocytic Leukemia	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:	
				(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				Congestive Heart Failure	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 1/13 1969 to 1/15 1969 that (2) (we) last saw the deceased alive on 1/15 1969 and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Joel Engelstein, M.D.				1/15/69	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		23E. FUNERAL DIRECTOR ADDRESS	
Joel Engelstein, M.D.		Johns Hopkins Hospital		LeCompte Funeral Service, Cambridge, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		1/18/69		Star Of The Sea Churchyard	
24D. LOCATION (City, town, or county)		24E. STATE		24F. DATE REC'D BY HEALTH DEPT.	
Golden Hill, Dor. Co., Md.				JAN 20 1969	
24G. NAME OF REGISTRAR		24H. FUNERAL DIRECTOR		24I. ADDRESS	
Charles E. Jenkins		LeCompte Funeral Service		Cambridge, Md.	



# FUNERAL DIRECTOR: IMPORTANT

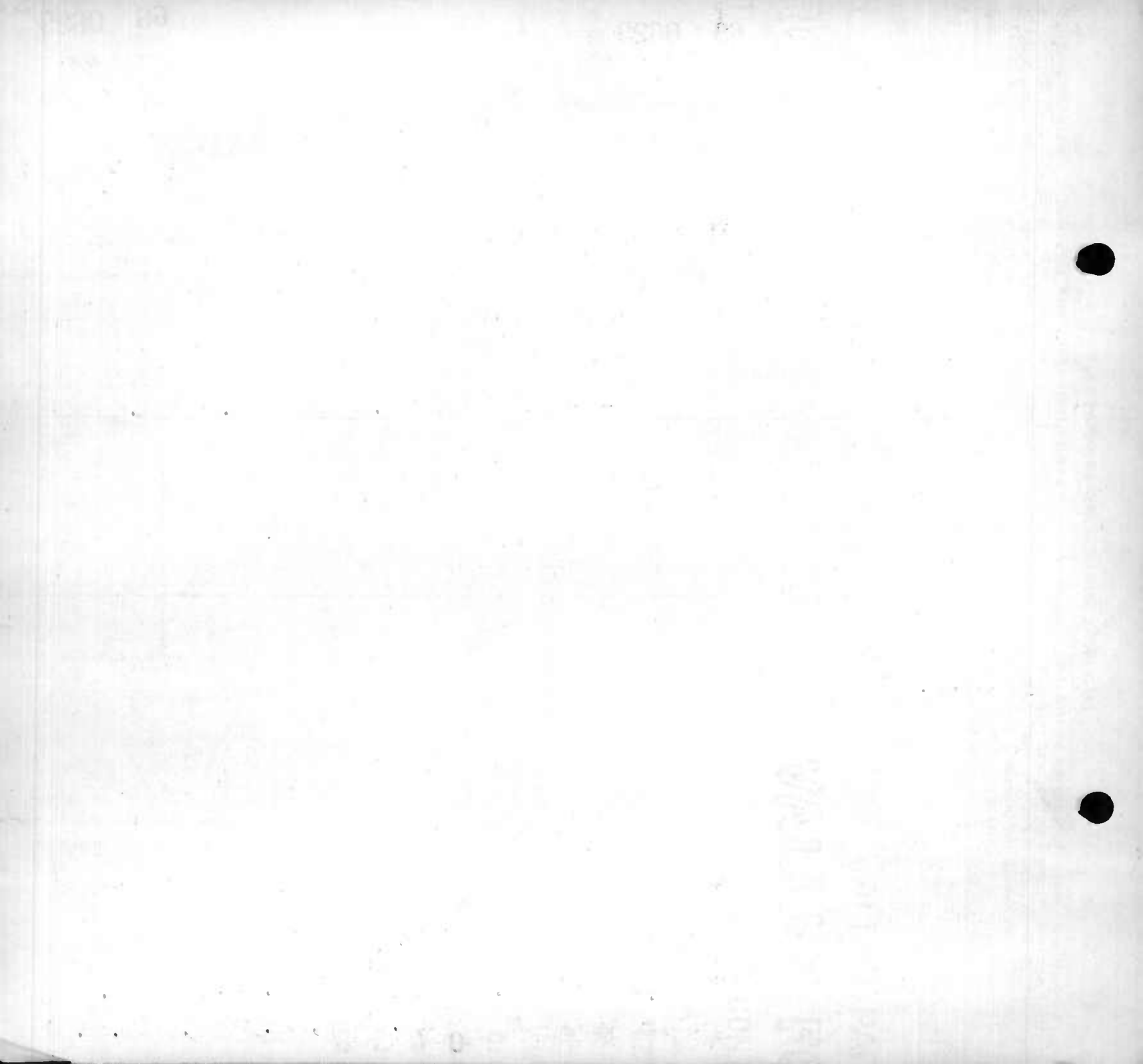
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## 69 0629 CERTIFICATE OF DEATH

REG. NO.

69 0629

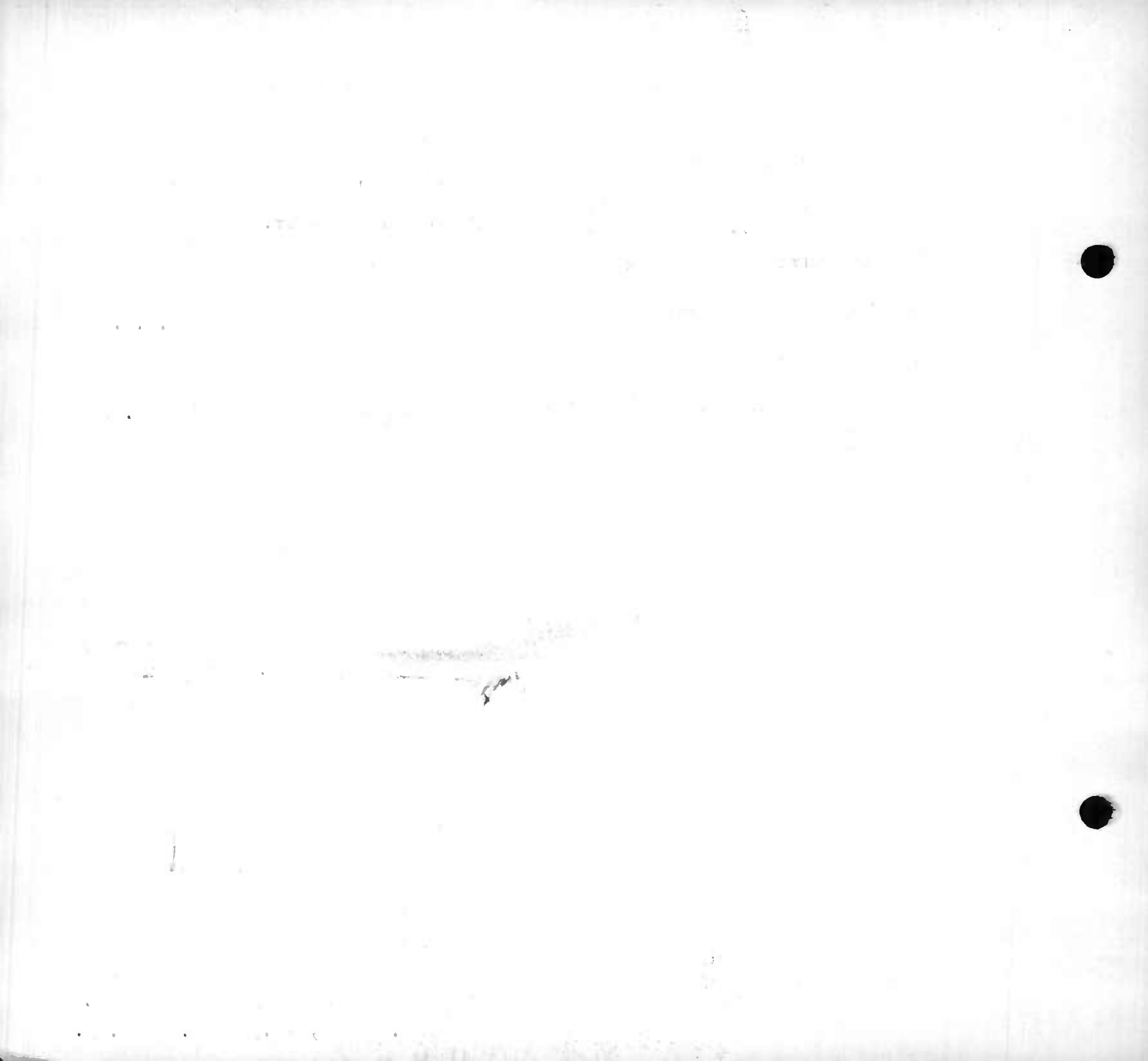
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MRS. ROSALIE VARNEY</b>		2. DATE AND HOUR OF DEATH <b>1-16-69 9:05 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b>		9-01	
FULL NAME OF HOSPITAL OR INSTITUTION <b>BON SECOURS HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY -----		B. DATE OF BIRTH <b>9-4-93</b> 9. AGE (In years last birthday) <b>75</b>	
11. BIRTHPLACE (State or foreign country) <b>NEW YORK STATE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>JOHN EVERETT Novakowski</b>	
14. MOTHER'S MAIDEN NAME <b>PAULINE ---</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>189-09-9371 B</b>	
17. INFORMANT <b>Samuel E. Varney</b>		ADDRESS <b>608 E. 38th St. Balto</b>		18. <b>428X</b> CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CONGESTIVE HEART FAILURE.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>DAYS.</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>MYOCARDIAL DISEASE</b>		DUE TO, OR AS A CONSEQUENCE OF: (B) <b>MYOCARDIAL DISEASE</b> (C) -----		<b>Mon.</b>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>12-27-1968</b> to <b>1-16-1969</b> , that (I) (we) lost saw the deceased alive on <b>1-16-1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Chaweng Ongkasuwan M.D.</b>		23B. DATE SIGNED <b>1-16-69</b>		23C. PHYSICIAN'S NAME (Type) <b>CHAWENG ONGKASUWAN M.D.</b>	
23D. ADDRESS <b>BON SECOURS HOSPITAL</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/20/69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>St. Joseph's Cem. Fullerton</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. County Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>	
25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>		25C. FUNERAL DIRECTOR <b>John A. Moran, Inc. 3000 E. Balto. St.</b>		25D. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

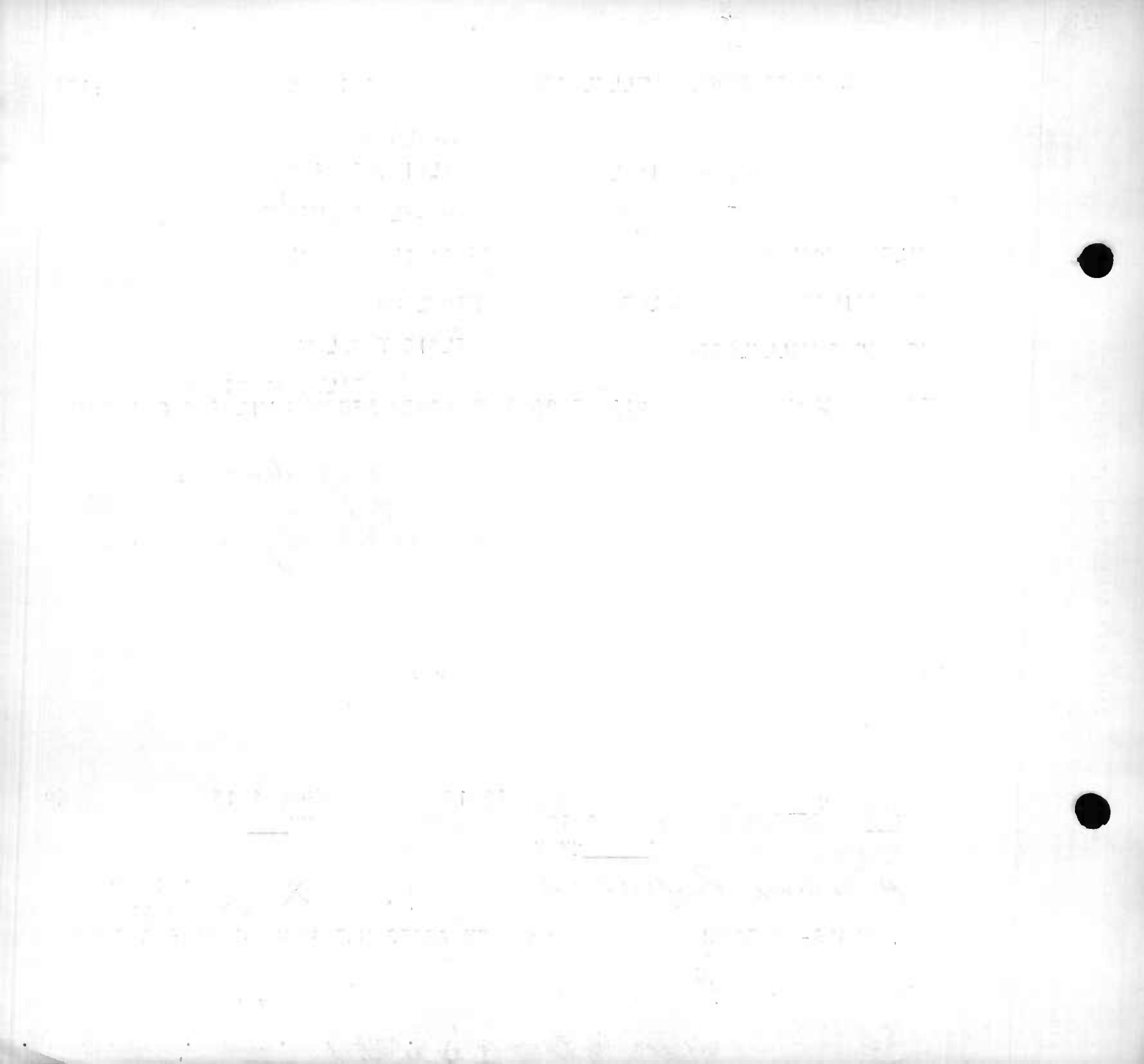
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0630		BALTIMORE CITY HEALTH DEPARTMENT, MARY C. REG. NO.		69 0630	
<b>CERTIFICATE OF DEATH 25-91</b>					
1. NAME OF DECEASED (Type or Print) <u>MARY GOEB</u>		2. DATE AND HOUR OF DEATH <u>JAN. 16, 1968, 5:01 P.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>33</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>JOHNS HOPKINS HOSPITAL</u> <u>601 N BROADWAY</u> <u>BALTIMORE, MARYLAND 21206</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>6-01</u> C. CITY OR TOWN <u>BALTIMORE,</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3 NORTH STREEPER ST.</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/25/ 91</u>	9. AGE (in years last birthday) <u>77</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>ALEXANDER BURNS</u>			
14. MOTHER'S MAIDEN NAME <u>ARABELLE CLARK</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>217 54 1914</u>		17. INFORMANT ADDRESS <u>Mildred Comegys 328 Dunkirk Rd. Box</u>			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) <u>285.1</u>		IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CARDIAC ARREST</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>RESP. ARREST</u>		<u>5 MIN</u>	
(C) <u>ANEMIA, NBP, ASCVD</u>				<u>YEARS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work <input type="checkbox"/> Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>JAN. 16</u> 19 <u>68</u> to <u>JAN 16</u> 19 <u>68</u> that (I) (we) last saw the deceased alive on <u>JAN 16</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John R. Soderka</u>		23B. DATE SIGNED <u>JAN. 16, 1968</u>		23C. PHYSICIAN'S NAME (Type) <u>JOHN R. SODOTKA MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/20/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	
24D. LOCATION <u>Baltimore</u>		24E. ADDRESS <u>Md.</u>		24F. CITY, TOWN, OR COUNTY (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>John A. Moran, Inc. 3000 E. Balto. St.</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		69 0631		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		69 0631							
1. NAME OF DECEASED (Type or Print) CHESTER ATWOOD WELLSLAGER				2. DATE AND HOUR OF DEATH 1 15 69 9:15A M.											
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN BALTIMORE 21222 D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 94 DELMAR AVENUE											
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 06 19 14		9. AGE (In years lost birthday) 54		11. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAB DRIVER				10B. KIND OF BUSINESS OR INDUSTRY CAB CO		11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME GEORGE E WELLSLAGER				14. MOTHER'S MAIDEN NAME ELSIE THURLOW											
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W W 2				16. SOCIAL SECURITY NO. 213 05 2359		17. INFORMANT BALTO MD 21229 ADDRESS ST AGNES RECORDS WILKENS & CATON									
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION 2										19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?									
22. I certify that (X) (this hospital) attended the deceased from 12 19 69 to 1 15 69 that (X) (we) last saw the deceased alive on 1 15 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.															
23A. SIGNATURE A. Shams Pirzadeh, M.D.										23B. DATE SIGNED 1 15 69					
23C. PHYSICIAN'S NAME (Type) A. SHAMS-PIRZADEH MD				23D. ADDRESS BALTO MD 21229 ST AGNES HOSPITAL WILKENS & CATON											
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/18/69		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland							
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1969				25B. NAME OF REGISTRAR Robert E. Taylor				25C. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Baltimore St.							





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Clarence Gittier</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> 1 17 1969 Hour 5:00 PM	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1736 Westphal Place</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour 1 17 1969 5:50 PM	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>12/17/1927</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) <b>41</b>		E. STREET AND NUMBER <b>1736 Westphal Place</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>CITY BALTIMORE</b>	
15. MOTHER'S MAIDEN NAME <b>LAURA WHEAT</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	
17. SOCIAL SECURITY NO. <b>215 22 3397</b>		18. INFORMANT <b>Mrs. Lois Gittier</b>	
19. CAUSE OF DEATH <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardio-vascular disease. DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute) <b>1 17 1969</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>Jan. 18, 1969</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1/22/69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>GLEN HAVEN CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>GLEN BURNIE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>	
25C. FUNERAL DIRECTOR <b>McColly</b>		25D. ADDRESS <b>130 E. Fort Ave.</b>	

VALLEY POLICE

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
69 0633				69 0633	
<b>CERTIFICATE OF DEATH</b>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		THOMAS SCHICKNER		JANUARY 16-1969 10:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
		MD.		19-02	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
1338 McHENRY ST.		BALTIMORE			
		E. STREET AND NUMBER			
		1338 McHENRY ST.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
MALE	WHITE		NOV. 24-1908	60	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
SALESMAN		FOOD DISTRIBUTOR		MARYLAND	
12. CITIZEN OF WHAT COUNTRY?		21. S. A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
HENRY SCHICKNER		IDA WHEELER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		213-03-8566		THOMAS H. SCHICKNER 229 TOWNSEND AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
I		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Several weeks	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1-14-69 to 1-17-69, that (I) (we) last saw the deceased alive on 1-14-69 and that (my) (our) apinlan death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
J. J. J. J. J.		1-17-69			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL	1-20-69	LOUDON PARK CEMETERY		BALTIMORE, MARYLAND.	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
JAN 20 1969	WALTERS	WALTERS FUN'L HOME		PRATT & STRICKER STS.	

1338 HENRY ST

MALE WHITE

HENRY SCHICKEL  
RED DISTRICT, MAR 1940  
TOA WHEELER

63-0631-101 HENRY SCHICKEL

BORIAL 1-20-41 LEONARD PARK CEMETERY, BALTIMORE, MARYLAND  
WALTER EARL HOME PATTERSON

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED <b>Phillip T. (Felix) Polek</b> (Type or Print) <b>PHIL THOMAS POLEK</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> Hour <input type="checkbox"/> M. <input type="checkbox"/> Estimated <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> Hour <input type="checkbox"/> M. <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 527 S. Bond Street</b>		3. DATE PRONOUNCED DEAD <b>January 16, 1969</b> <b>7:55 A.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Oct. 24, 1909</b>		10. AGE (In years lost birthday) <b>59</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>La borer</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Scow Captain</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes World War II</b>		17. SOCIAL SECURITY NO. <b>214-03-2423</b>	
13. FATHER'S NAME <b>Thomas Polek</b>		15. MOTHER'S MAIDEN NAME <b>Maryanna Zagata</b>	
18. INFORMANT <b>Henry Polek</b>		ADDRESS <b>527 S. Bond Street #21231</b>	
19. <b>E 8871 X</b>		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Acute ethylism</b> DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II <b>Cerebro-cranial injuries</b>			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>	
22D. TIME OF INJURY (APPROX.) <b>1-15-69 or ?</b>		22E. INJURY OCCURRED <b>2</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>527 S. Bond Street</b>		22F. HOW DID INJURY OCCUR? <b>Apparently fell</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>January 16, 1969</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/20/69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Holy Rosary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore County, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fackey</b>	
25C. FUNERAL DIRECTOR <b>George A. Weber</b>		ADDRESS <b>705 S. Ann St. #21231</b>	

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MILLEN  
CHRYSLER  
CORPORATION

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 0635

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>LEO J. KASPRZAK</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>January 16, 1969</b> 8:43 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>001724 Portugal Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 16, 1969 8:43 P. M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>6/9/1907</b>		10. AGE (In years last birthday) <b>61</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Machine Shop</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW 11</b>		17. SOCIAL SECURITY NO. <b>215-07-4989</b>	
15. MOTHER'S MAIDEN NAME <b>Josephine Augustyniak</b>		18. INFORMANT <b>Mary Martin-1018 Collwood Rd-Baltimore, Md.</b>	
19. <b>4124</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/20/69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cem.,</b>		24D. LOCATION (City, town, or county) (State) <b>5501 Fredk Ave-Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>		25B. NAME OF REGISTRAR <i>Robert E. Farber</i>	
25C. FUNERAL DIRECTOR <b>George A. Weber</b>		ADDRESS <b>705 South Ann Street</b>	



X



WALLACE X. ROGERS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

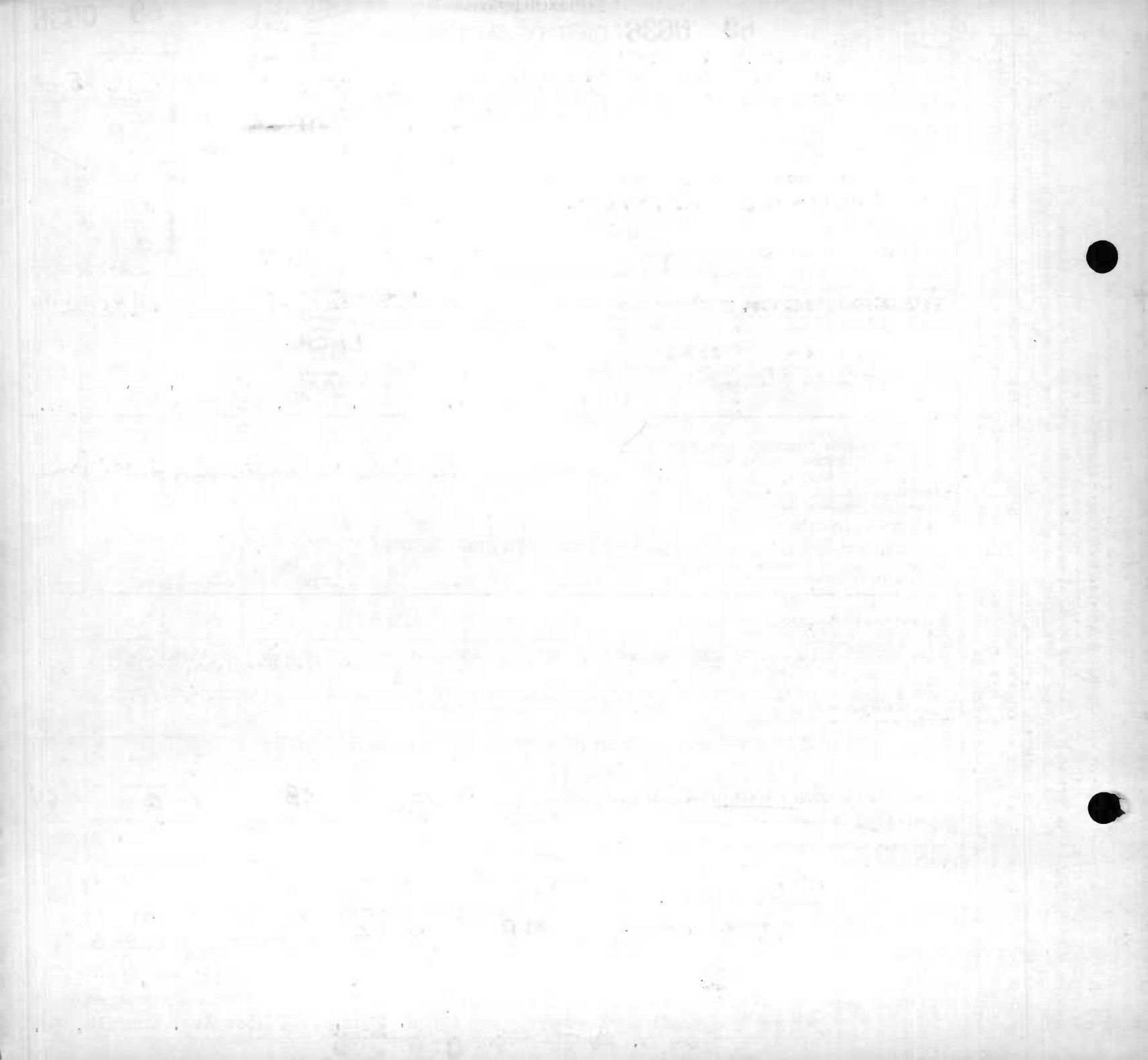
# 69 0636 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

69 0636

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Audrey W. Moore</b> <b>MOORE MR. AUDREY. W.</b>		2. DATE AND HOUR OF DEATH <b>JAN. 16. 1969 12.35 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>35 CHURCH HOME AND HOSPITAL</b> <b>BALTIMORE. MD. 21231.</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Church Home &amp; Hospital</b>		C. CITY OR TOWN <b>DUNDALK</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>10-4-01</b>		9. AGE (In years last birthday) <b>67</b>		10. If Under 1 Yr. Months Days 11. If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bethlehem Steel Co. Foreman</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN.</b>		13. FATHER'S NAME <b>WILLIAM MOORE.</b>		14. MOTHER'S MAIDEN NAME <b>LAURA.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213 07 0778</b>		17. INFORMANT (Wife) <b>Dundalk, Md. 21222</b> <b>Mrs. Alice E. Moore, 8104 Murray Point Rd.</b>	
18. <b>593.21</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Renal insufficiency &amp; failure</b>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-30</b> <b>1968</b> to <b>1-16</b> <b>1969</b> , that (I) (we) last saw the deceased alive on <b>1-16</b> <b>1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Jose F. Mier, Sr.</b>		M.D. DEGREE <b>M.D.</b> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>1-16-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Jose F. Mier, Sr.</b>		23D. ADDRESS <b>100 N. Broadway</b> <b>Charmers Home &amp; Hotel</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/20/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>	
24D. LOCATION <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Talley</b>		25C. FUNERAL DIRECTOR <b>John J. Duda</b>	
ADDRESS <b>7922 Wise Ave. Dundalk, Md.</b>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 0637	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Laura Helen MATHERS Lloyd</i>		2. DATE AND HOUR OF DEATH <i>1/15/69 4:50 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>31 BALTIMORE CITY HOSPITALS</i> <i>4940 Eastern Ave</i> <i>Baltimore, Maryland #21224</i>			C. CITY OR TOWN <i>DUNDALK</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <i>Female</i>			6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY <i>HOUSEWIFE</i>		8. DATE OF BIRTH <i>10-10-87</i>
13. FATHER'S NAME <i>Jug Mathers</i>			14. MOTHER'S MAIDEN NAME <i>Jane Irons</i>		9. AGE (In years last birthday) <i>81</i>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			16. SOCIAL SECURITY NO. <i>164-22-7744</i>		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>
17. INFORMANT <i>BCH Records: 4940 Eastern Ave</i> <i>Baltimore, Maryland #21224</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>TUMOR METASTASES</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 mos.</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>PRIMARY SITE NOT KNOWN</i> <i>POSSIBLY GASTRIC</i>			(B) DUE TO, OR AS A CONSEQUENCE OF: <i>6 yrn mos.</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12/9</i> 19 <i>68</i> to <i>1/15</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>1/15</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Robert A. Rosenbaum, M.D.</i>				23B. DATE SIGNED <i>1/15/69</i>	
23C. PHYSICIAN'S NAME (Type) <i>Robert A. Rosenbaum M. D.</i>				23D. ADDRESS <i>Baltimore City Hospitals</i> <i>4940 Eastern Ave Baltimore, Md. #21224</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>1/18/1969</i>		24C. NAME OF CEMETERY or CREMATORY <i>GRANDS. FAITH</i>	
24D. LOCATION (City, town, or county) (State) <i>BALTO. CO., MD.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 20 1969</i>			
25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Walter Frank Buckley</i>		25D. ADDRESS <i>1420 N. ...</i>	



# FUNERAL DIRECTOR: IMPORTANT

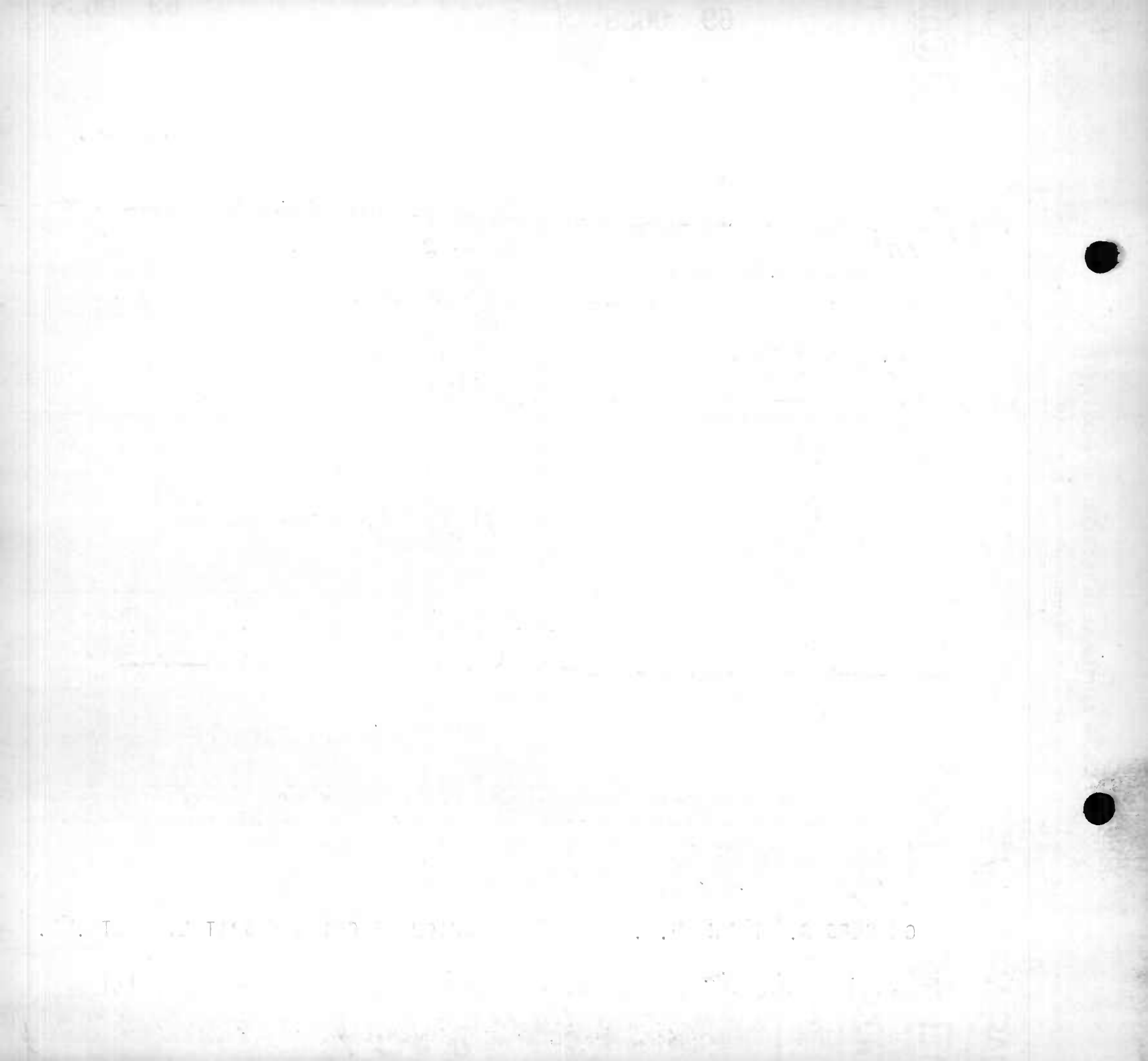
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0638

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

69 0638 REG. NO.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>CLARK, CHARLES H.</b>		2. DATE AND HOUR OF DEATH <b>1-16-69</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>13-07</b>		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSP</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
44		E. STREET AND NUMBER <b>3614 KESWICK RD</b>			
5. SEX <b>MA</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/26/00</b>	9. AGE (In years lost birthday) <b>68</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>US</b>		13. FATHER'S NAME <b>Edward Clark</b>		14. MOTHER'S MAIDEN NAME <b>Carrie Roach</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>225-01-1011</b>		17. INFORMANT <b>VELINA ALCOBN ROUTE #6 REIDSVILLE, N.C.</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>AC M I</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>AC M I</b> (B) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF: (C) —		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4d</b>	
19. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) —	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? —		22. I certify that (I) (this hospital) attended the deceased from <b>1/12</b> 19 <b>69</b> to <b>1/16</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>1/16</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Charles S. Brown M.D.</b>		23B. DATE SIGNED <b>1/16/69</b>			
23C. PHYSICIAN'S NAME (Type) <b>CHARLES S. BROWN M.D.</b>		23D. ADDRESS <b>UNION MEMORIAL HOSPITAL, BALTO. MD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Jan 20, 1969</b>	24C. NAME OF CEMETERY or CREMATORY <b>St. Marys Cem (Hampden)</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>	25B. NAME OF REGISTRAR <b>Blaise E. Farkner</b>	25C. FUNERAL DIRECTOR <b>Frank W. Jutz</b>		ADDRESS <b>814 W. 36th St 21211</b>	



5-160

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>JAMES L. SOAPER</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <b>1</b> Day <b>12</b> Year <b>69</b> Hour <b>10:45 a.</b> Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2444 Harriet Ave.</b>		3. DATE PRONOUNCED DEAD Month <b>January</b> Day <b>12</b> Year <b>1969</b> Hour <b>10:45 a.</b>	
6. SEX <b>Male</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>25-72</b>	
7. RACE <b>White</b>		C. CITY OR TOWN <b>Balto.</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>12-19-27</b>		E. STREET AND NUMBER <b>2444 Harriet Ave.</b>	
10. AGE (In years lost birthday) <b>41</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Richard S. Soaper</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Md. Match Co.</b>	
15. MOTHER'S MAIDEN NAME <b>Margaret B.</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W.W.II</b>	
17. SOCIAL SECURITY NO. <b>220-22-2194</b>		18. INFORMANT <b>Mrs. Theresa Cochrane</b>	
19. <b>345.71</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). (A) IMMEDIATE CAUSE <b>Epilepsy</b> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		ADDRESS <b>3703 St. Victor St.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>No</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Edward F. Wilson</b> M.D. EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b> DATE SIGNED <b>1/13/69</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-15-1969</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>	
25C. FUNERAL DIRECTOR <b>George J. Gonce</b>		ADDRESS <b>4001 Ritchie Hgwy., Balto</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

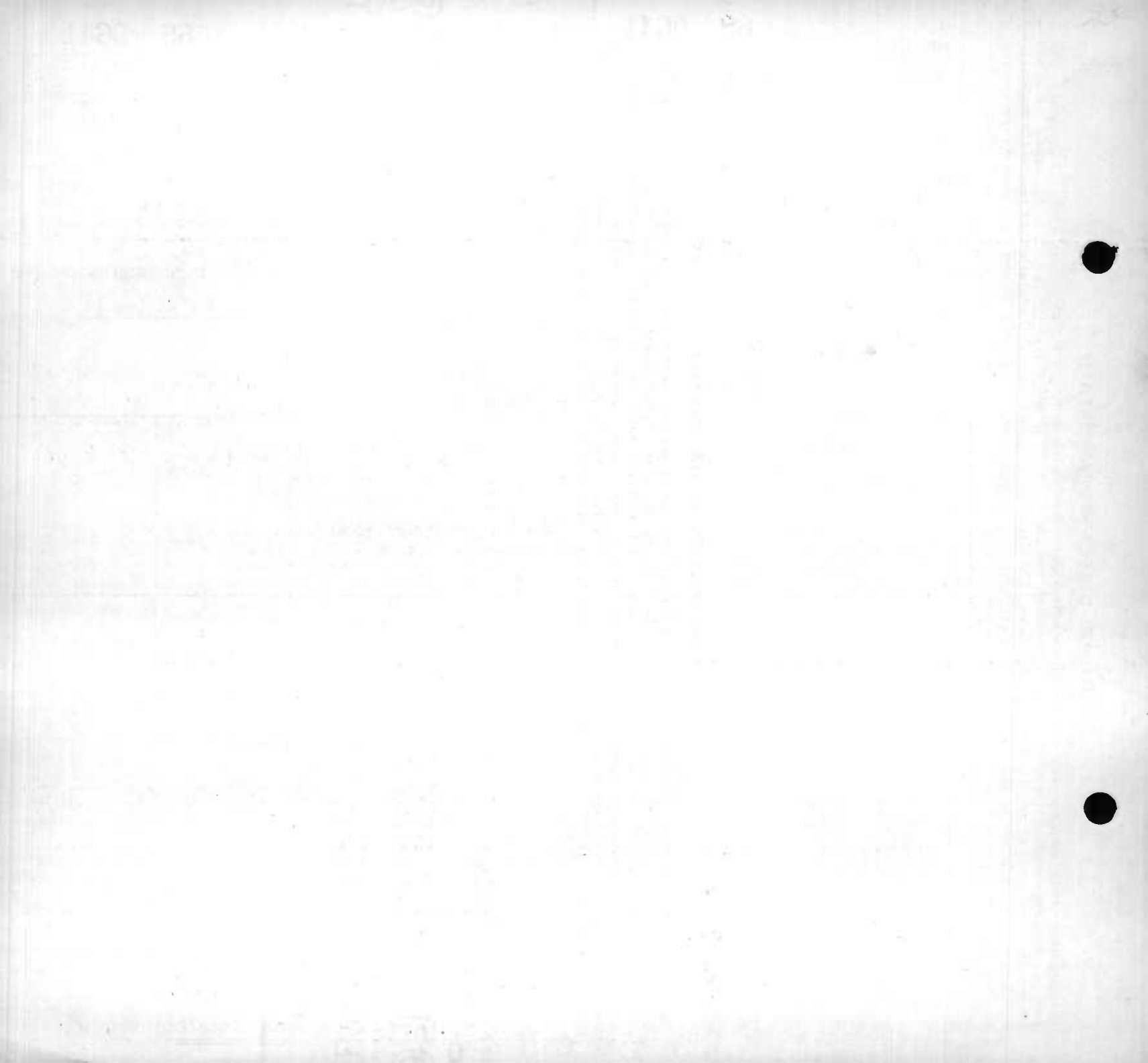
BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.				69 0640			
CERTIFICATE OF DEATH															
1. NAME OF DECEASED (Type or Print) <b>JOHN H. ROSE, SR.</b>								2. DATE AND HOUR OF DEATH <b>1/14/69</b>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>44 Union mem. Hospital</b>								4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>md</b> B. COUNTY <b>27-10</b>							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>44 Union mem. Hospital</b>								C. CITY OR TOWN <b>Balto.</b>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
								E. STREET AND NUMBER <b>4423 St. Georges ave</b>							
5. SEX <b>M</b>		6. RACE <b>N</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/23/09</b>		9. AGE (In years last birthday) <b>59</b>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Custodian</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>School</b>				11. BIRTHPLACE (State or foreign country) <b>md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Howard A. Rose</b>								14. MOTHER'S MAIDEN NAME <b>Fannie Farnett</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>217-07-7540</b>				17. INFORMANT <b>Ira Rose 4423 St. Geo. ave.</b>				ADDRESS			
18. <b>441.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>RUPTURE of ANEURYSM</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 Hour</b>							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>HYPERTENSION, arterial</b>								DUE TO, OR AS A CONSEQUENCE OF: <b>4 years</b>							
								<b>ARTERIOSCLEROSIS</b> <b>5 years</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>NONE</b>								<b>INFLUENZA</b> <b>2 Wks</b>							
19A. DATE OF OPERATION <b>NONE</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <b>NO</b>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NONE</b>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NONE</b>				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?							
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased on <b>Jan 14 1969</b> to <b>Jan 14 1969</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Jan 14 1969</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.															
23A. SIGNATURE <b>A.S. Chalfant MD</b>								Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>Jan 16, 1969</b>			
23C. PHYSICIAN'S NAME (Type) <b>A.S. CHALFANT</b>								23D. ADDRESS <b>6210 YORK ROAD BALTIMORE MD</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Buried</b>				24B. DATE <b>1/18/69</b>				24C. NAME of CEMETERY or CREMATORY <b>Pleasant Rest</b>				24D. LOCATION (City, town, or county) (State) <b>Towson, Balto. Co. Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>				25B. NAME OF REGISTRAR <b>Polym. E. Fajana</b>				25C. FUNERAL DIRECTOR <b>Wm. P. Chaturian Jr. - 1701 McCarroll St. Balto. Md.</b>				ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.
69 0641		CERTIFICATE OF DEATH		69 0641
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH
		PAUL Y. SOO		JAN 15, 1969 3 <sup>15</sup> A.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY		
UNION MEMORIAL HOSP. BALTIMORE 21218		MD. Baltimore 53-00		
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?
		REISTERSTOWN		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
		E. STREET AND NUMBER		
		121 GRINDON DRIVE		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
M	ORIENTAL		2/18/20	48
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
SUPERINTENDENT				CHINA
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
Pek Hin Soo		Pui Y. Woo		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
UNK.		356-30-4842		MRS. JENNIE SOO, SAME
18. 430.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		SUBARACHNOID HEMORRHAGE		
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) BERRY ANEURYSM, LT. INT. CAROTID DUE TO, OR AS A CONSEQUENCE OF:		
		(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
NONE				No
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from JAN 14 1969 to JAN 15 1969, that (1) (we) last saw the deceased alive on JAN 14 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE		23B. DATE SIGNED		
W. H. M. FINNEY		Jan 15, 1969		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
W. H. M. FINNEY				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY
Burial		1/18/69		Finksburg Cemetery
				Finksburg, Md.
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS
JAN 20 1969		J. F. Eline & Sons		Reisterstown, Md.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

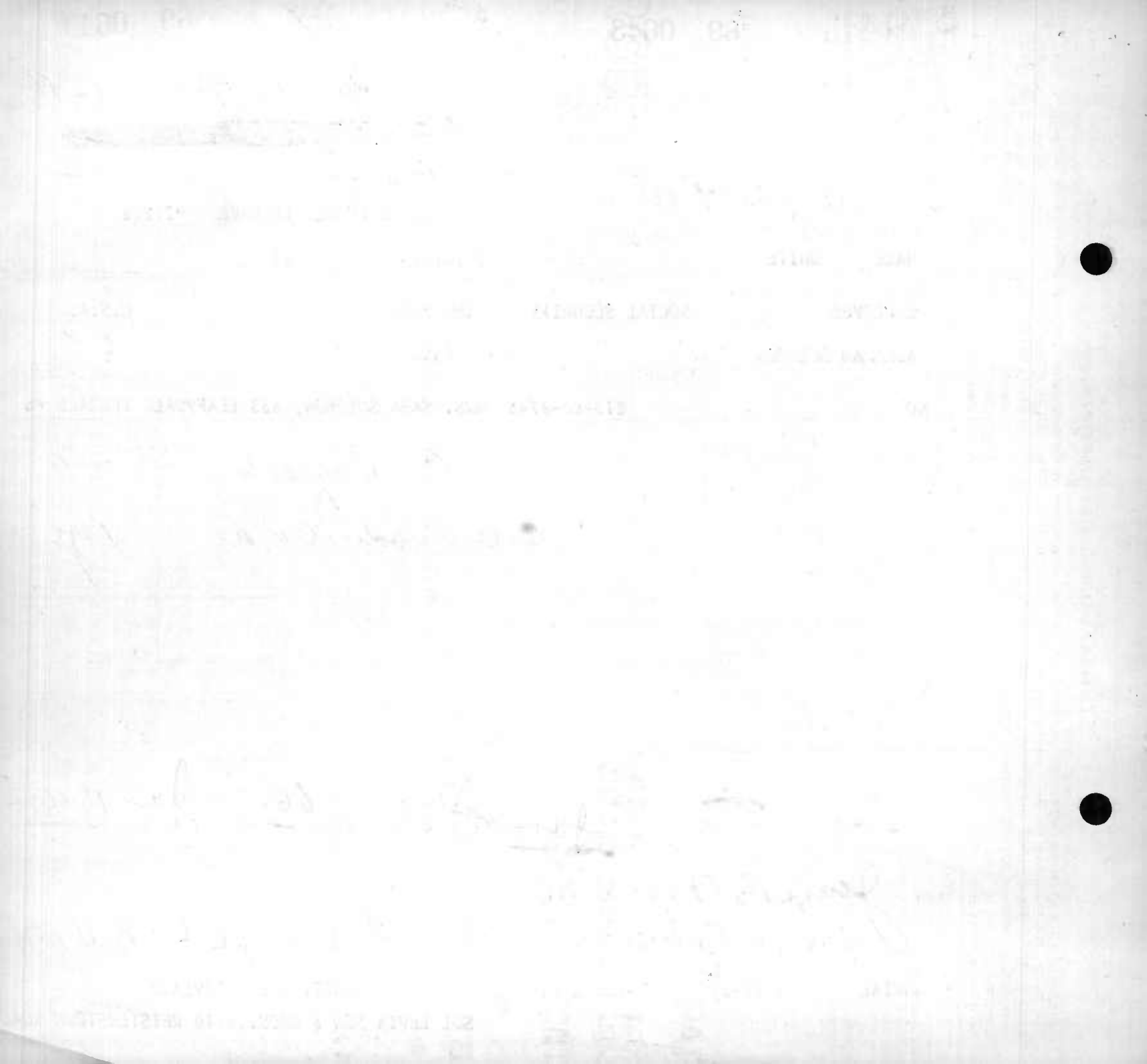
BIRTH NO. 69 0642				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 69 0642	
1. NAME OF DECEASED (Type or Print) <b>K. Sybilla Sohn</b>				2. DATE AND HOUR OF DEATH <b>1-13-69 2 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital at institution, give street address or location) <b>3308 Baymore Ave</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>27-44</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO</b> D. STREET ADDRESS (If rural, give location) <b>3308 Baymore Ave</b>			
5. SEX <b>F</b>	6. RACE <b>W.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>1/20/88</b>	9. AGE (In years lost birthday) <b>81</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO MD.</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		12. CITIZEN OF WHAT COUNTRY? <b>—</b>		
13. FATHER'S NAME <b>Jacob Sohn</b>				14. MOTHER'S MAIDEN NAME <b>Anna Zink</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>—</b>			16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>Henry Sohn</b>		ADDRESS <b>—</b>
18. <b>437.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral arteriosclerosis</b>				CAUSE OF DEATH (A) DUE TO <b>Cerebral arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>II</b>				(B) DUE TO <b>—</b>		(C) DUE TO <b>—</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>—</b>							
19A. DATE OF OPERATION <b>—</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20A. AUTOPSY? (Yes or No) <b>—</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>—</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>—</b>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>—</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>—</b>			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>1958</b> to <b>Jan 13</b> 19 <b>69</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Jan. 6</b> 19 <b>69</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <b>Ronald Jandorf</b> M.D.						23B. DATE SIGNED <b>1-13-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>R Donald Jandorf</b> M.D.				23D. ADDRESS <b>7403 Hartford Rd</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/15/69</b>		24C. NAME of CEMETERY or CREMATORY <b>Immanuel</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>		25B. NAME OF REGISTRAR <b>—</b>		25C. FUNERAL DIRECTOR <b>—</b>		ADDRESS <b>6067 Hay Rd</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0643		Baltimore City Health Department		69 0643	
5-455		X		REG. NO.	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <i>Victor Solomon</i>			2. DATE AND HOUR OF DEATH <i>Jan 15 1969 5-11 P</i> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Scenic Hospital Baltimore</i>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>Baltimore</i>		
			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER <i>633 LEAFYDALE TERRACE #21208</i>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-1-1913</b>	9. AGE (In years last birthday) <b>55</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>EMPLOYEE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SOCIAL SECURITY</b>		11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>ABRAHAM SOLOMON</b>		14. MOTHER'S MAIDEN NAME <b>ANNA ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-20-9748</b>		17. INFORMANT ADDRESS <b>MRS. SARA SOLOMON, 633 LEAFYDALE TERRACE #8</b>	
18. CAUSE OF DEATH					
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cronyobacter</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2h</i>
			(B) <i>arteriosclerotic CVD</i>		<i>1yr</i>
			(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>June 1966</i> to <i>Jan 15 1969</i> , that (I) (we) last saw the deceased alive on <i>Jan 15 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Joseph B Gross M.D.</i>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>Joseph B Gross</i>				23D. ADDRESS <i>6911 Park Heights L Baltimore</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1-17-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>WORKMENS CIRCLE</b>	
24D. LOCATION <b>BALTIMORE, MARYLAND</b>		24E. FUNERAL DIRECTOR ADDRESS <b>SOL LEVIN SON &amp; BROS., 6010 REISTERSTOWN ROAD</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>		25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVIN SON &amp; BROS., 6010 REISTERSTOWN ROAD</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
69 0644		CERTIFICATE OF DEATH		69 0644	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
FANNIE SCHNEIDER			JANUARY 15, 1969 12:45 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  PALL MALL NURSING HOME			A. STATE MARYLAND		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY BALTIMORE		
90			C. CITY OR TOWN RANDALLSTOWN		
			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
			E. STREET AND NUMBER 9031 SAMOSET ROAD		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
FEMALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	6-14-1879	89	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE		AT HOME		HUNGARY	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
? FRANK			UNKNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
NO			NO		
17. INFORMANT			ADDRESS		
MISS ROSE SCHNEIDER, 9031 SAMOSET ROAD			RANDALLSTOWN, MD. 21133		
18. 440.91 CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				3 days	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES				10 years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 49 to 1/15 1969, that (I) (we) last saw the deceased alive on 1/15 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
DR. ISRAEL ZINBERG				1/15/69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
				4000 W. NORTHERN PKWY.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		1-16-69		HEBREW FRIENDSHIP	
24D. LOCATION (City, town, or county)		24E. STATE			
BALTIMORE, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 20 1969		R. B. S. 2, F. J. S. 2		SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>ANNE L. NATHANSON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> _____ M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>42 Sinai Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 13, 1969 2:27 P.M.</b>	
6. SEX <b>female</b>		7. RACE <b>white</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>4-13-1896</b>		10. AGE (In years lost birthday) <b>72</b>	
11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
15. MOTHER'S MAIDEN NAME <b>CELIA ?</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	
17. SOCIAL SECURITY NO. <b>NO</b>		18. INFORMANT <b>MR. CARL L. NATHANSON</b>	
19. <b>412.4</b>		ADDRESS <b>10919 HUNTCLEIFF DR. OWINGS MILLS, MARYLAND 21117</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b>		CAUSE OF DEATH <b>Arteriosclerotic Cardiovascular Disease</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Werner U. Spitz</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-15-69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>HAR ZION TIFERETH ISRAEL</b>		24D. LOCATION (City, town, or county) (State) <b>ROSEDALE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>	
25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC.</b>		ADDRESS <b>6010 REISTERSTOWN ROAD, BALTIMORE 21215</b>	

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4-13-1946

RACHEL LEVINSKY

U.S.A.

RUSSIA

AT HOME

HOUSING

NO

NO

MR. CARL J. WATKINS, 12119 WATKINS  
GLENVIEW, ILL., HARVARD CITY

RECEIVED

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RUSSIA

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-160 69 0646		BALTIMORE CITY HEALTH DEPARTMENT	
12-29-96		CERTIFICATE OF DEATH	
BIRTH NO. 12-29-96		REG. NO. 219-32-1416-A-69 0646	
1. NAME OF DECEASED (Type or Print) <b>HYMAN PIVAR</b>		2. DATE AND HOUR OF DEATH <b>1/14/69 6 AM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>MARYLAND</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Jewish Convalescent Home</b> <b>70 4601 Pall Mall Road.</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>3513 Hilton Road</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/29/96</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PROPRIETOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>REAL ESTATE</b>	9. AGE (In years last birthday) <b>72</b>
11. BIRTHPLACE (State or foreign country) <b>England.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DAVID PIVAR</b>		14. MOTHER'S MAIDEN NAME <b>HINDA ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MRS. MINNIE PIVAR, 3513 HILTON ROAD</b>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Acute myocardial infarction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Generalized arteriosclerosis</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
19A. DATE OF OPERATION <b>none</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>	
20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>N/A</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>none</b>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>none</b>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>N/A</b>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>N/A</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>12/13 1968</b> to <b>1/14 1969</b> , that (I) (we) last saw the deceased alive on <b>1/13/69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Stanley M. Rosen M.D.</b>		23B. DATE SIGNED <b>1/14/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>STANLEY M. ROSEN</b>		23D. ADDRESS <b>4000 W. NORTHERN PKWY.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-15-69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>BETH TFILOH</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fajana</b>	
25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>		ADDRESS	

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 0647

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>LEONARD JACKSON</b>		2. DATE Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 1 13 69		3. DATE Month Day Year January 13, 1969	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 20-04		6. SEX Male	
7. RACE Colored		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH 3-14-45	
10. AGE (In years lost birthday) 23		11. BIRTHPLACE (State or foreign country) Howard County, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Leonard Jackson		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Alice Jackson	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT Mrs. Ruth Sedgwick 4626 Rokeby Rd.	

19. <b>E965X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Peritonitis</u> DUE TO, OR AS A CONSEQUENCE OF: gunshot wound of the abdomen (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					

20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) YES	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? On Street in front of 1525 Penn. Ave.	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 1 4 69 11:40		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject shot several times during altercation	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Edward F. Wilson</u>		EXAMINER'S NAME (Type) Edward F. Wilson, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
				DATE SIGNED 1/13/69	

24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-17-69		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Westport (Baltimore) Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 20 1969		25B. NAME OF REGISTRAR Robert E. Jackson	
25C. FUNERAL DIRECTOR Joseph L. Rice		25D. ADDRESS 2222 W. North Ave.			



7120 88

WALTER

Serial 717-68 Mr. Robert (Robert) M. ...  
Joseph M. ...



m-300

69 0648

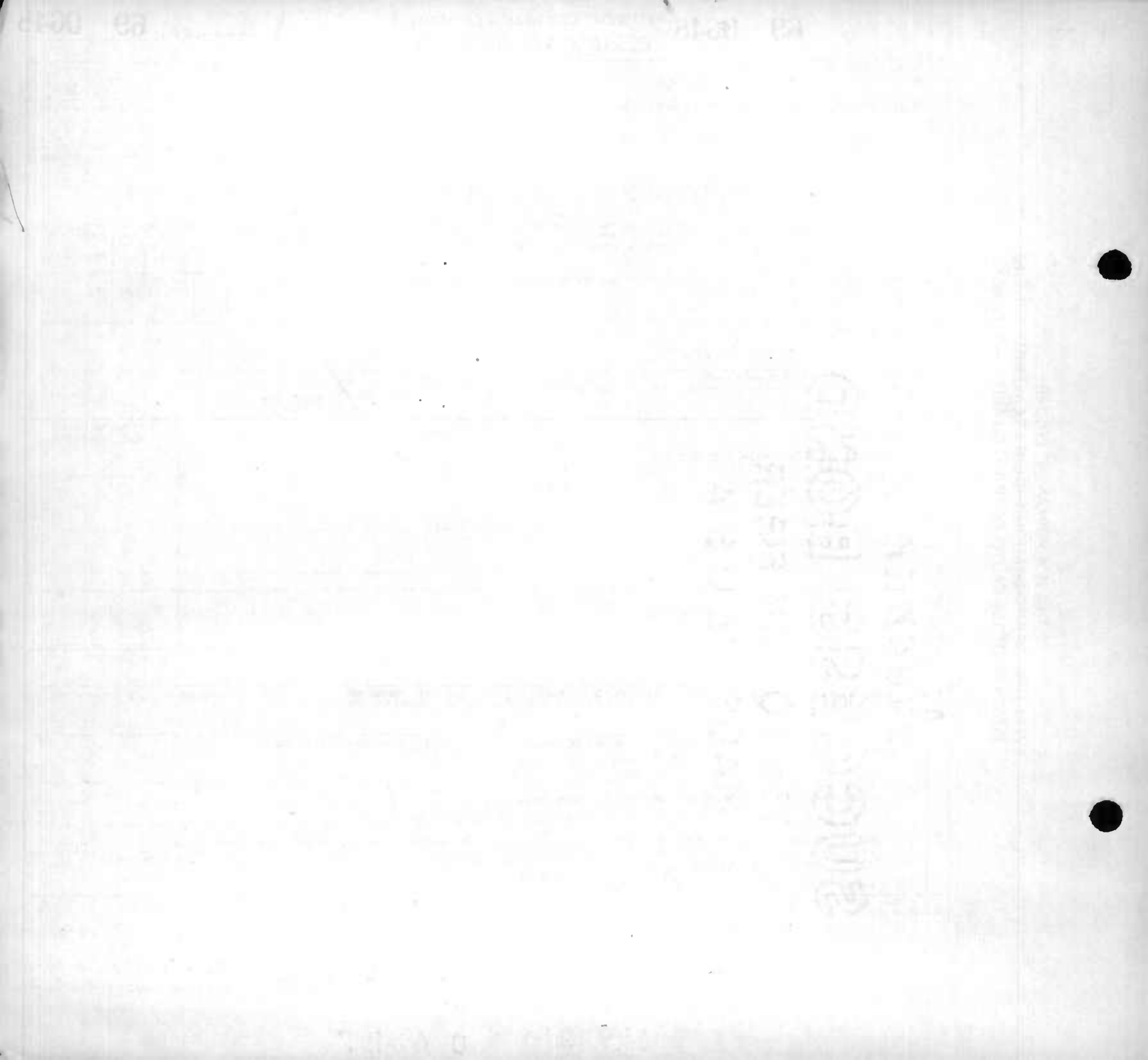
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 69 0648

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Ethel P. Maith</b>		2. DATE OF DEATH <b>Jan 13, 1969</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. AGE (In years last birthday)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>00 1810 Baker Street</b>		A. STATE <b>Maryland</b> B. COUNTY <b>15-02</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
		D. STREET ADDRESS (If rural, give location) <b>1810 Baker Street</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cohored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Feb. 5, 1911</b>	9. AGE (In years last birthday) <b>57</b>	If Under 1 Year Months Days Hours Min.
10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Julius Freeman</b>		14. MOTHER'S MAIDEN NAME <b>Hester Bond</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mrs. Mildred Trezevant 4009 W. Cold Spring Lane</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>277X1</b>		CAUSE OF DEATH (A) <b>Hypertensive C.V. disease</b> DUE TO (B) <b>Obesity</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>unk</b> <b>unk</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>15 Feb 69</b> to <b>19 65</b> to <b>23 Dec 68</b> that (I) (we) last saw the deceased alive on <b>23 Dec 68</b> and that in (my) (our) opinion death occurred at <b>23 Dec 68</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>Ronald B. Lyle</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		23B. ADDRESS <b>501 Chanty Hill Rd</b>		23C. DATE SIGNED <b>13 Jan 69</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-18-69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Westport (Baltimore) Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>		25B. NAME OF REGISTRAR <b>R. B. E. Freeman</b>	
25C. FUNERAL DIRECTOR <b>Joseph L. Ruel</b>		25D. ADDRESS <b>2222 W. North Ave Baltimore, Md</b>			

THIS IS A PERMANENT RECORD.  
EVERY ITEM OF INFORMATION SHOULD BE CAREFULLY SUPPLIED.  
PLEASE WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.

1 9 6 9 0 0 0 0 6 4 7



FUNERAL DIRECTOR: IMPORTANT

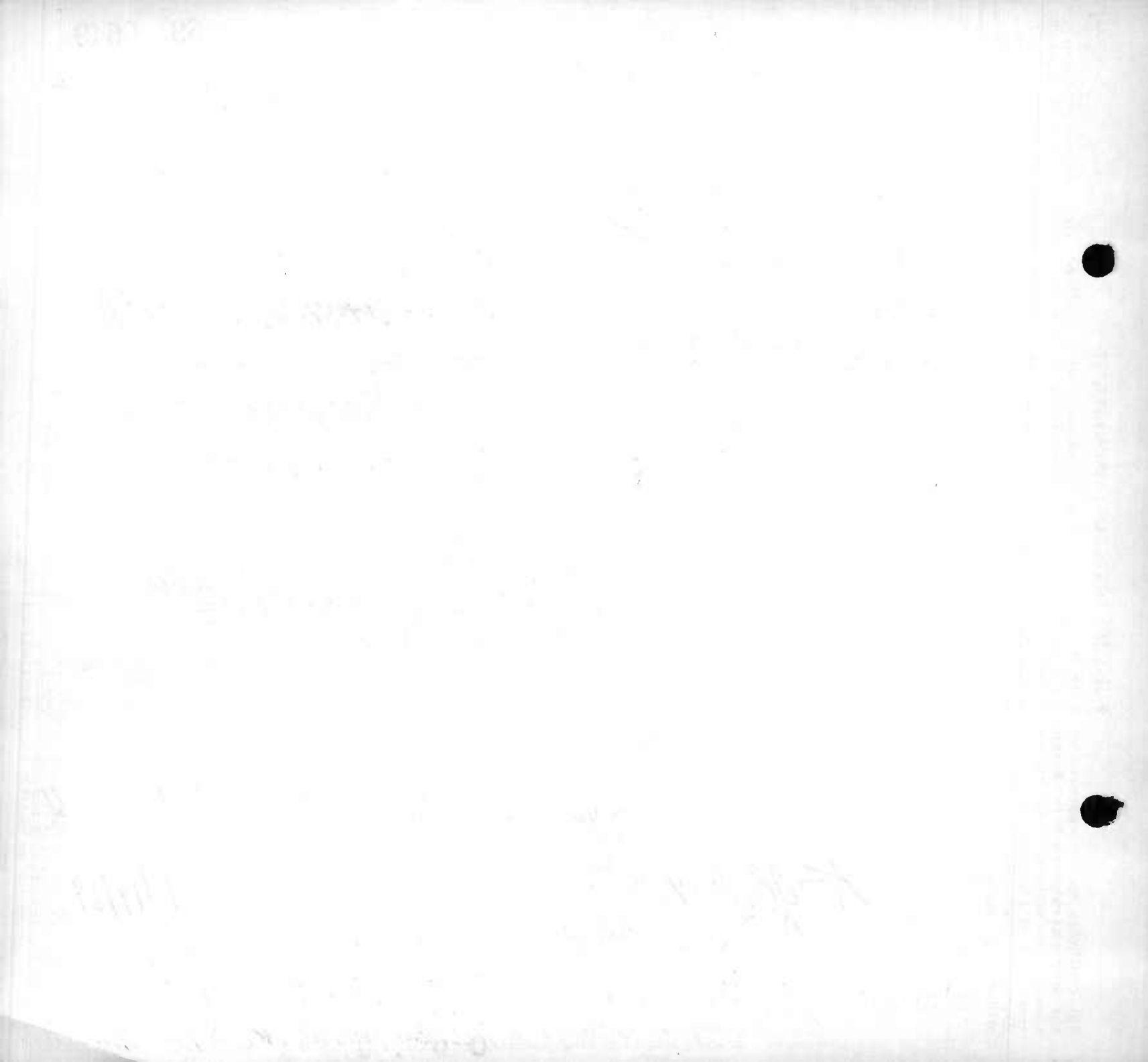
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0649

BALTIMORE CITY HEALTH DEPARTMENT  
CITY OF BALTIMORE  
BALTIMORE CITY HEALTH DEPARTMENT  
CITY OF BALTIMORE

REG. NO. 69 0649

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JAMES McBRIDE</b>		2. DATE AND HOUR OF DEATH <b>1/19/69 7:40 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>38 University Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) A. STATE <b>BALTO</b> B. COUNTY <b>MD</b> C. CITY OR TOWN <b>MD</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1020 Lombard St.</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 19, 1925</b>	9. AGE (in years last birthday) <b>43</b>	10. Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Bluefield W. Va.</b>	
13. FATHER'S NAME <b>Albert McBride</b>		14. MOTHER'S MAIDEN NAME <b>Bentley Leonard</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. Maryanna McBride</b>	
18. <b>571.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshterio, etc. It means the disease, injury or complication which caused death.) <b>MI and aspiration pneumonia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Esophageal varices.</b> <b>↑ Portal pressure 2° to Laennec's cirrhosis</b> <b>HEPATO-RENAL SYNDROME</b> <b>ASCUD</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <b>HEPATO-RENAL SYNDROME</b> <b>ASCUD</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR	
22. I certify that (I) (this hospital) attended the deceased from <b>1/17/69</b> to <b>1/19/69</b> and that (I) (we) lost saw the deceased alive on <b>1/19/69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>AS G. LUSHAKOV</b>				23B. DATE SIGNED <b>1/19/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>AS G. LUSHAKOV</b>				23D. ADDRESS <b>University Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/23/69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem.</b>	
24D. LOCATION <b>Balto. Md.</b>		24E. (City, town or county)		24F. (State)	
25A. DATE RECEIVED BY HEALTH DEPT. <b>JAN 20 1969</b>		25B. NAME OF REGISTRAR <b>Robert S. Johnson</b>		25C. FUNERAL DIRECTOR <b>William F. Hane</b>	
25D. ADDRESS <b>319 N. Scholander St.</b>					



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
**69 0650 CERTIFICATE OF DEATH**

REG. NO. **69 0650**

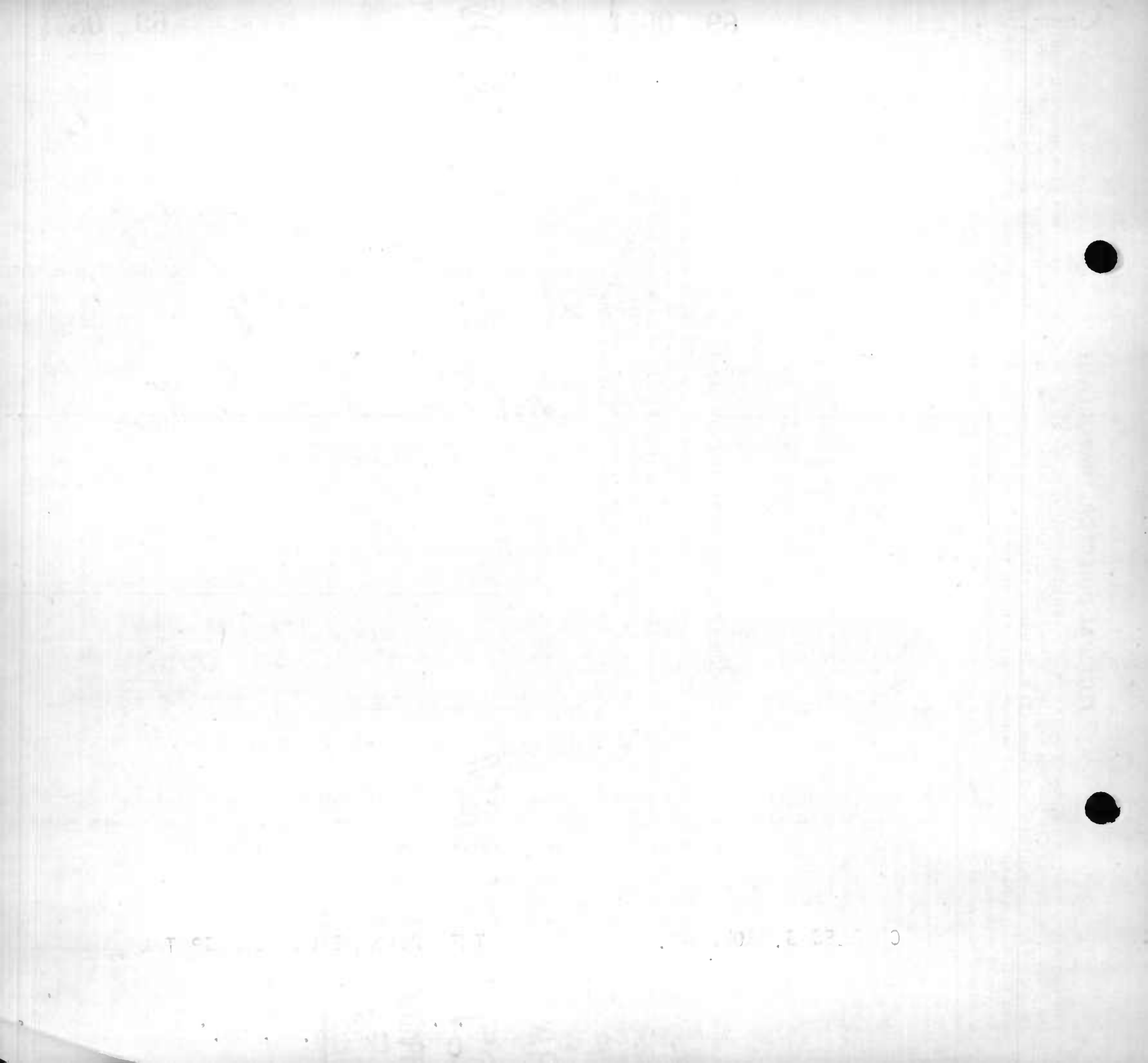
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Sara E. Kelly</b>		2. DATE AND HOUR OF DEATH <b>January 17, 1969 12:40 A.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>9-01</b>						
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 Gould Convalescerium</b>			C. CITY OR TOWN <b>Baltimore 21218</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
			E. STREET AND NUMBER <b>3921 Yolando Road</b>						
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 26, 1892</b>	9. AGE (In years lost birthday) <b>76</b>				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Stewart &amp; Company</b>		11. BIRTHPLACE (State or foreign country) <b>Parkersburg, W. Va.</b>					
13. FATHER'S NAME <b>Patrick Kelly</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Welch</b>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>234-34-8277A</b>		17. INFORMANT <b>Mrs. Dora Frazier</b>					
				ADDRESS <b>(Same)</b>					
18. CAUSE OF DEATH									
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; vertical-align: top;"> <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                         </td> <td style="width: 50%; vertical-align: top;">                             (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute pulmonary edema</b>                               (B) <b>Chronic myocarditis</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic C-V disease</b>                               (C) <b>Pyelonephritis</b> </td> </tr> <tr> <td colspan="2" style="text-align: right;">APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>15 yrs</b> <b>5 yrs</b></td> </tr> </table>						<b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute pulmonary edema</b>  (B) <b>Chronic myocarditis</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic C-V disease</b>  (C) <b>Pyelonephritis</b>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>15 yrs</b> <b>5 yrs</b>	
<b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute pulmonary edema</b>  (B) <b>Chronic myocarditis</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic C-V disease</b>  (C) <b>Pyelonephritis</b>								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>15 yrs</b> <b>5 yrs</b>									
19A. DATE OF OPERATION <b>0</b>									
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>July 25 1967</b> to <b>January 17 1969</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>Jan 16 1969</b> and that in (my) ( <del>and</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.									
23A. SIGNATURE <b>Dr. Harold V. Harbold</b>				23B. DATE SIGNED <b>Jan. 17, 1969</b>					
23C. PHYSICIAN'S NAME (Type) <b>Dr. Harold V. Harbold</b>				23D. ADDRESS <b>4706 Harford Road</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Rem. Burial</b>		24B. DATE <b>1/21/69</b>		24C. NAME of CEMETERY or CREMATORY <b>St. Xavier</b>					
24D. LOCATION <b>Wood County, W. Va.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>							
25A. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25B. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co.</b>							
		ADDRESS <b>4905 York Rd. Balto. 12, Md.</b>							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>O'NEILL MILDRED ANN</b>		2. DATE AND HOUR OF DEATH <b>1/17/69 12 50 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>9-01</b>		C. CITY OR TOWN <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hosp</b> <b>44</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>4/23/01</b>		9. AGE (In years last birthday) <b>67</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>New York, N.Y.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Edward Cronkwhite</b>		14. MOTHER'S MAIDEN NAME <b>Florence White</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-07-1959</b>		17. INFORMANT <b>Terrence J. O'Neill</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarct</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>11 days</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1/15</b> 19 <b>69</b> to <b>1/17</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>1/17</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Charles S. Brown</b>		23B. DATE SIGNED <b>1/17/69</b>		23C. PHYSICIAN'S NAME (Type) <b>CHARLES S. BROWN MD.</b>	
23D. ADDRESS <b>Union Memorial Hosp</b> <b>THE UNION MEMORIAL HOSPITAL</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>1/20/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Schuyler</b>		25C. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>	
25D. ADDRESS <b>Balto. 12, Md.</b>					





FUNERAL DIRECTOR: IMPORTANT

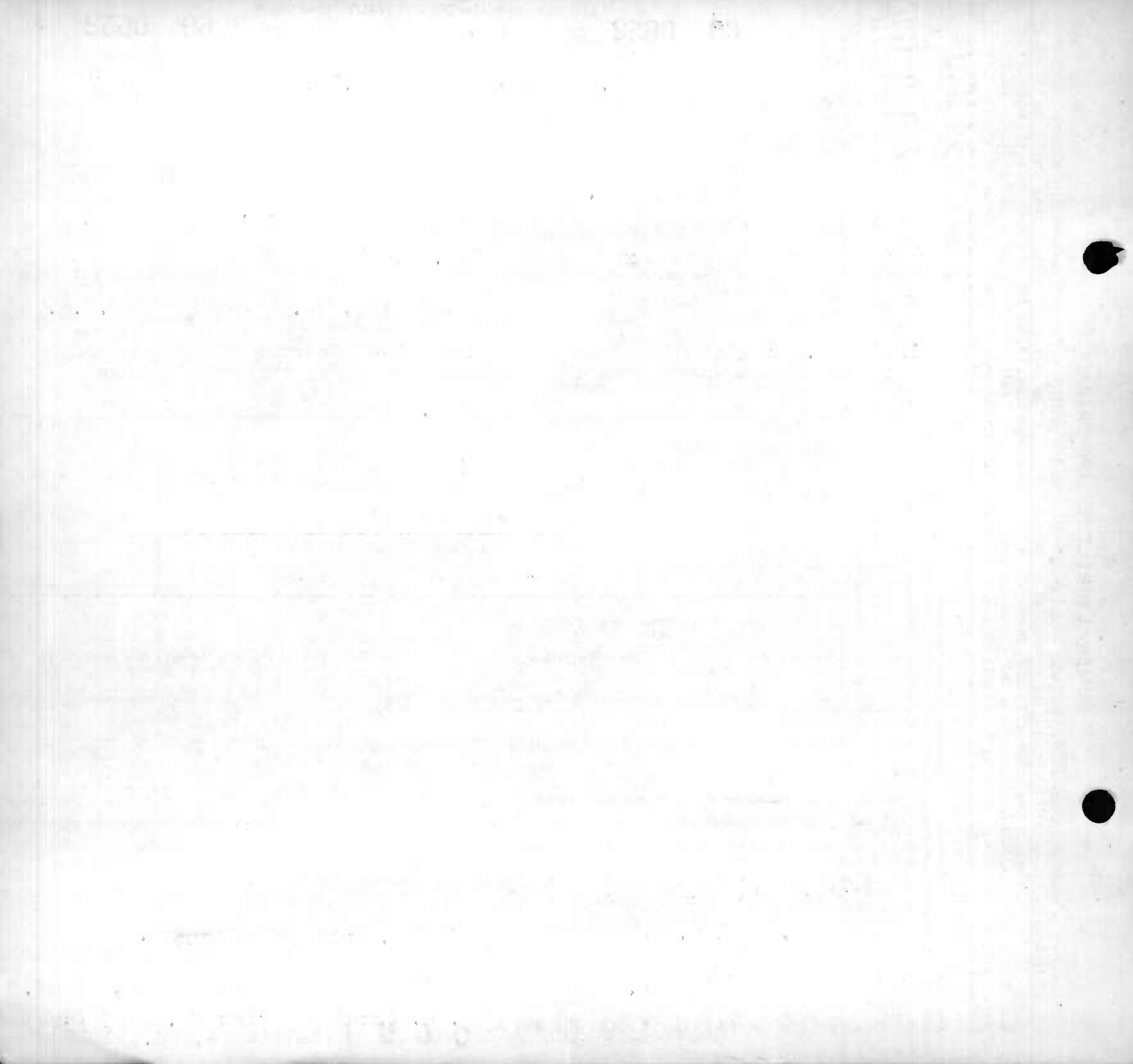
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 69 0652 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 69 0652

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Willie R. Bowland		Jan. 17, 1969 4:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  4506 Fernhill Ave.				A. STATE Maryland	
				B. COUNTY	
5. SEX F				6. RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH Jan. 20, 1874	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				9. AGE (In years last birthday) 94	
10B. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (State or foreign country) Snow Hill, Md.	
13. FATHER'S NAME William T. Riffin				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. MOTHER'S MAIDEN NAME Marcelena Houston				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No	
16. SOCIAL SECURITY NO.				17. INFORMANT Mrs. Virginia Riggan (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (1) Cerebral Thrombosis 5 days (B) Anterior Sclerotic Heart Disease 6 yrs. (C) Generalized Arterio Sclerosis -	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan. 15 - Jan. 17, 1969, to Jan. 17, 1969, and that (I) (we) lost saw the deceased alive on Jan. 15 - Jan. 17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Earl L. Chambers, M.D.				23B. DATE SIGNED 1/18/69	
23C. PHYSICIAN'S NAME (Type) Dr. Earl L. Chambers				23D. ADDRESS 100 W. Coldspring Lane	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/20/69		24C. NAME OF CEMETERY or CREMATORY St. Andrews Episcopal Church Princess Anne, Md.	
24D. LOCATION (City, town, or county)		24E. STATE Md.		24F. ADDRESS	
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1969		25B. NAME OF REGISTRAR R. G. Jenkins		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Rd Baltimore, Md. 21212	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 0653				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 0653			
1. NAME OF DECEASED (Type or Print) <b>GROSS, BARBARA</b>				2. DATE AND HOUR OF DEATH <b>1/16/69 8:10 A</b>				M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND,</b> B. COUNTY <b>26-12</b>							
FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE</b> <b>BALTIMORE, MARYLAND 21224</b>				C. CITY OR TOWN <b>BALTIMORE</b>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <b>4940 EASTERN AVENUE</b>											
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-27-48</b>	9. AGE (In years last birthday) <b>20</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>PERRY, ROBERT (F. FATHER)</b>				14. MOTHER'S MAIDEN NAME <b>PERRY, MAEBIRT (F. MOTHER)</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.				17. INFORMANT <b>B.C.H. RECORDS</b> ADDRESS <b>4940 EASTERN AVENUE</b>			
18. <b>444.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Portals Cerebellar degeneration</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Cardio respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Peritonitis</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Infarcted Colon</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>1/14</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Bowel obstruction</b>				20A. AUTOPSY? (Yes or No) <b>NO</b>			
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?				22. I certify that (I) (this hospital) attended the deceased from <b>7-21</b> <b>19 64</b> to <b>1-16</b> <b>1969</b> , that (I) (we) lost saw the deceased alive on <b>1-16</b> <b>19</b> <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Stephen N. Bennett</b> DEGREE				23B. DATE SIGNED <b>1/16/69</b>							
23C. PHYSICIAN'S NAME (Type) <b>STEPHEN BENNETT M.D.</b> DEGREE				23D. ADDRESS <b>4940 EASTERN AVENUE</b> <b>BALTIMORE, MARYLAND 21224</b>				23E. ADDRESS <b>BALTIMORE CITY HOSPITAL</b>			
24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) <b>Burial 1-20-69</b>				24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn</b>				24D. LOCATION (City, town, or county) (State) <b>Balta City Md</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>				25B. NAME OF REGISTRAR <b>Robert E. [unclear]</b>				25C. FUNERAL DIRECTOR <b>Louise St. [unclear]</b> ADDRESS <b>1539 E. North Ave</b>			

Carrie Augusten Fisher

Portrait ~~enlargement~~

Portrait of Mr.

<sup>Portrait</sup> of Mr. ~~Charles~~ <sup>Charles</sup> ~~Chapman~~

Portrait of Mr.

Stephen H. Bennett

1/10

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 0654

BIRTH NO. 66-87562

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>ELANA GATEWOOD</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>1 16 69 3:35 p.m.</b>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hospital D.O.A.</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 16, 1969 3:35 p.m.</b>			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-03</b>							
6. SEX <b>Female</b>	7. RACE <b>Colored</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>12-17-66</b>		10. AGE (In years lost birthday) <b>2</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		13. FATHER'S NAME <b>LEE WILLIAMS</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		17. SOCIAL SECURITY NO. <b>N/A</b>		15. MOTHER'S MAIDEN NAME <b>BONA GATEWOOD</b>			
18. INFORMANT <b>Bona Gatewood</b>		ADDRESS <b>2849 W. Garrison Ave. Baltimore, Md.</b>					
19. <b>E890X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Smoke and soot inhalation incident</b> DUE TO, OR AS A CONSEQUENCE OF: <b>to conflagration</b>  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____			
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <b>NO</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>1618 Bentalou St. 15-03</b>			
22D. TIME OF INJURY (APPROX.) <b>1 16 69 3:15p</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Conflagration</b>			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1/17/79</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-18-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>		25B. NAME OF REGISTRAR <b>R. E. Farley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>MORTON &amp; DYETT FUNERAL HOMES, INC. 1701 Laurens St., Balto., Md. 21217</b>			

WALTON

FOR

69 0655

BALTIMORE CITY HEALTH DEPARTMENT

69 0655

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>KELLY McCRAY JR.</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>1 15 69 10:10a M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>5125 N. Aisquith St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 15, 1969 10:10 M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Colored</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>3-20-1919</b>		10. AGE (In years, last birthday) <b>50</b>	
11. BIRTHPLACE (State or foreign country) <b>Manning, S. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unkn</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Unkn</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Anna E. McCray</b>		ADDRESS <b>809 Mt. Holly St. Baltimore, Maryland</b>	
19. <b>093.9</b>		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Luetic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Edward F. Wilson</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-19-69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT FUNERAL HOME</b>		ADDRESS <b>1701 Laurens St., Balto., Md. 21217</b>	



WALTER BROWN

WALTER BROWN



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 0656

BIRTH NO. 63-14748

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>ERICA LASSITER</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 1 16 69 4:25 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Lutheran Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 16, 1969 4:25 p.m.</b>	
6. SEX <b>Female</b>		7. RACE <b>Colored</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>6-3-43</b>		10. AGE (In years last birthday) <b>5</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>infant</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>none</b>	
15. MOTHER'S MAIDEN NAME <b>Barbara Coleman</b>		18. INFORMANT <b>Mr. Eric Lassiter</b>	
19. <b>E 890X</b>		ADDRESS <b>2861 Edgecombe Circle</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <b>Smoke and soot inhalation incident to conflagration</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>House</b>	
22D. TIME (Month) (Day) (Year) (Hour) <b>1 16 69 3:15p</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>1618 Bentalou St.</b>		22F. HOW DID INJURY OCCUR? <b>Conflagration (baby sitter's home)</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		DATE SIGNED <b>1/17/69</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/20/69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>		25B. NAME OF REGISTRAR <b>MORTON + DYETT</b>	
25C. FUNERAL DIRECTOR <b>1701 LAURENS</b>		ADDRESS	

11-11-11

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K-652

69 0657

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 0657

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Cornell Kernes

2. DATE OF DEATH Known ☐ Month Day Year Hour  
Estimated ☒ 1 17 1969 7:00 PM

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

39 Provident Hospital

3. DATE PRONOUNCED DEAD Month Day Year Hour  
1 17 1969 7:05 PM

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY 15-13

6. SEX

Male

7. RACE

C

8. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

12-17-1947

10. AGE (In years last birthday)

21

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

4217 Pimlico Road

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Alexander Kernes

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Unknown

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Helen Kernes

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Mrs. Helen Kernes-4217 Pimlico Rd.

MEDICAL CERTIFICATION	19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)	CAUSE OF DEATH Gunshot wound of chest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO, OR AS A CONSEQUENCE OF:	
	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	(C) DUE TO, OR AS A CONSEQUENCE OF:	

20A. DATE OF OPERATION	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	21. AUTOPSY? (Yes or No) yes
------------------------	--	---------------------------------

22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Intersection Roberts St.-Linden Ave.
22D. TIME OF INJURY (APPROX.) Jan. 17, 69 7:00 PM	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	22F. HOW DID INJURY OCCUR? shot during argument

23. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE: *Werner U. Spitz* M.D.  
EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: Jan 18, 1969

24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 1-21-69	24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park	24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1969	25B. NAME OF REGISTRAR J. E. [unclear]	25C. FUNERAL DIRECTOR Morton & Dyett F. H.	ADDRESS 1701 Laurens St

N 873179690000656

84 083

083 083

VALLEY POLICE

25/8/84

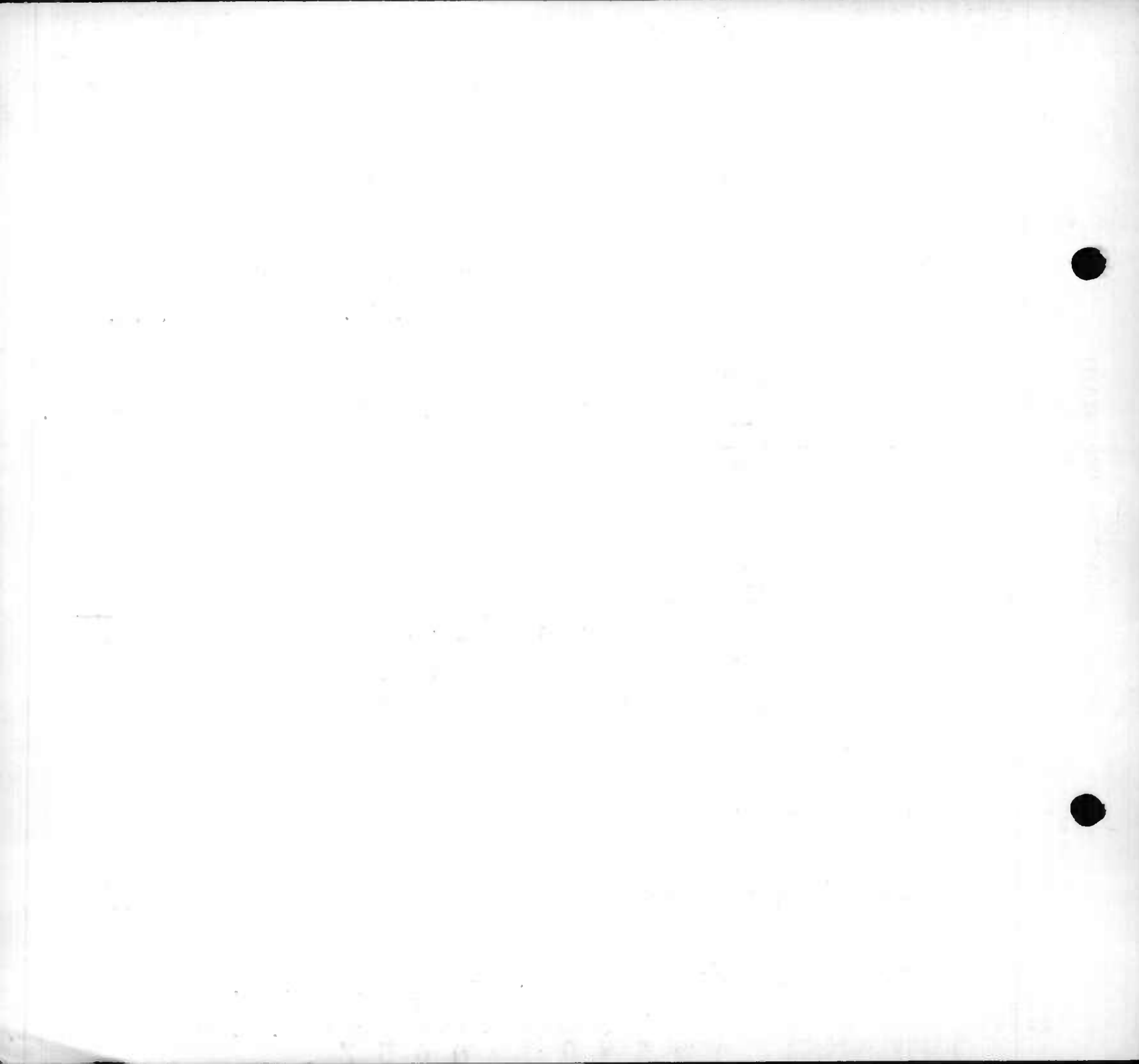
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
69 0658 CERTIFICATE OF DEATH

REG. NO. 69 0658

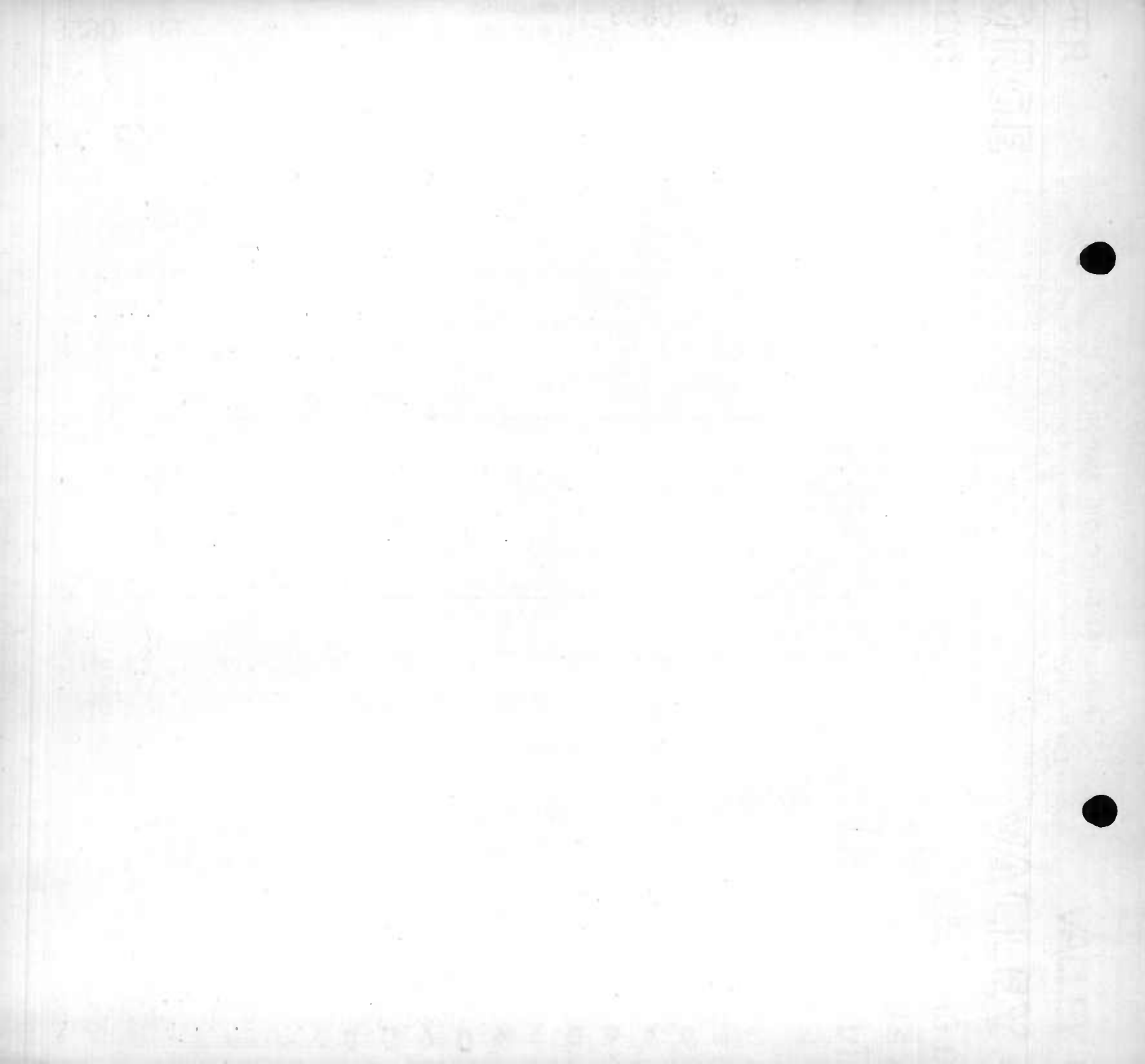
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>James Cuths</u>		2. DATE AND HOUR OF DEATH <u>1/14/69</u> <u>7:15 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <u>Lincoln Hospital of Baltimore</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>27-17</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Lincoln Hospital of Baltimore</u>				C. CITY OR TOWN <u>Baltimore</u>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>3305 Paton Avenue</u>	
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-1-1903</u>	9. AGE (In years last birthday) <u>65</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto, Md.</u>	
13. FATHER'S NAME <u>Unkown</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-12-9083</u>		17. INFORMANT <u>Mrs. Annie Massie-3305 Paton Ave.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>197.8 18250.9</u> <u>Carcinoma of Liver</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>CHF</u> <u>Diabetes mellitus</u>				<u>2 years weeks</u> <u>2 years</u>	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1/4</u> 19 <u>69</u> to <u>1/4</u> 19 <u>69</u> that (I) (we) lost saw the deceased alive on <u>1/4</u> 19 <u>69</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Stanford H. Mahlow MD</u>				23B. DATE SIGNED <u>1/14/69</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-17-69</u>		24C. NAME of CEMETERY or CREMATORY <u>Arbutus Mem. Park</u>	
				24D. LOCATION <u>Balto, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber</u>		25C. FUNERAL DIRECTOR <u>Morton &amp; Dyett F. H.</u>	
				ADDRESS <u>1701 Laurens St.</u>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0659 BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 0659	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Helm Pauline</i>		2. DATE AND HOUR OF DEATH <i>1-17-69 1:25 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>md.</i> B. COUNTY <i>15-47</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>46 Lutheran Hosp. of Md.</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>3025 Windsor Avenue</i>	
5. SEX <i>H</i>	6. RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 20, 1890</i>	9. AGE (In years last birthday) <i>78</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Jackson</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Nina McKnight-Ridgewood Ave</i>	
18. <i>486X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>myocardial infarction</i> (B) <i>pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>1-5</i> 19 <i>69</i> to <i>1-17</i> 19 <i>69</i> . that (I) (we) last saw the deceased alive on <i>1-17 1:25 PM</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>H. C. Park M.D.</i>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <i>Huang Kyoung Park</i>	
23D. ADDRESS <i>730 Ashburton St. Baltimore, 21216</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-21-69</i>	
24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn Cemetery</i>		24D. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		24E. (State)	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <i>Morton &amp; Dyett F. H.</i>	
25D. ADDRESS <i>1701 Laurens St.</i>					

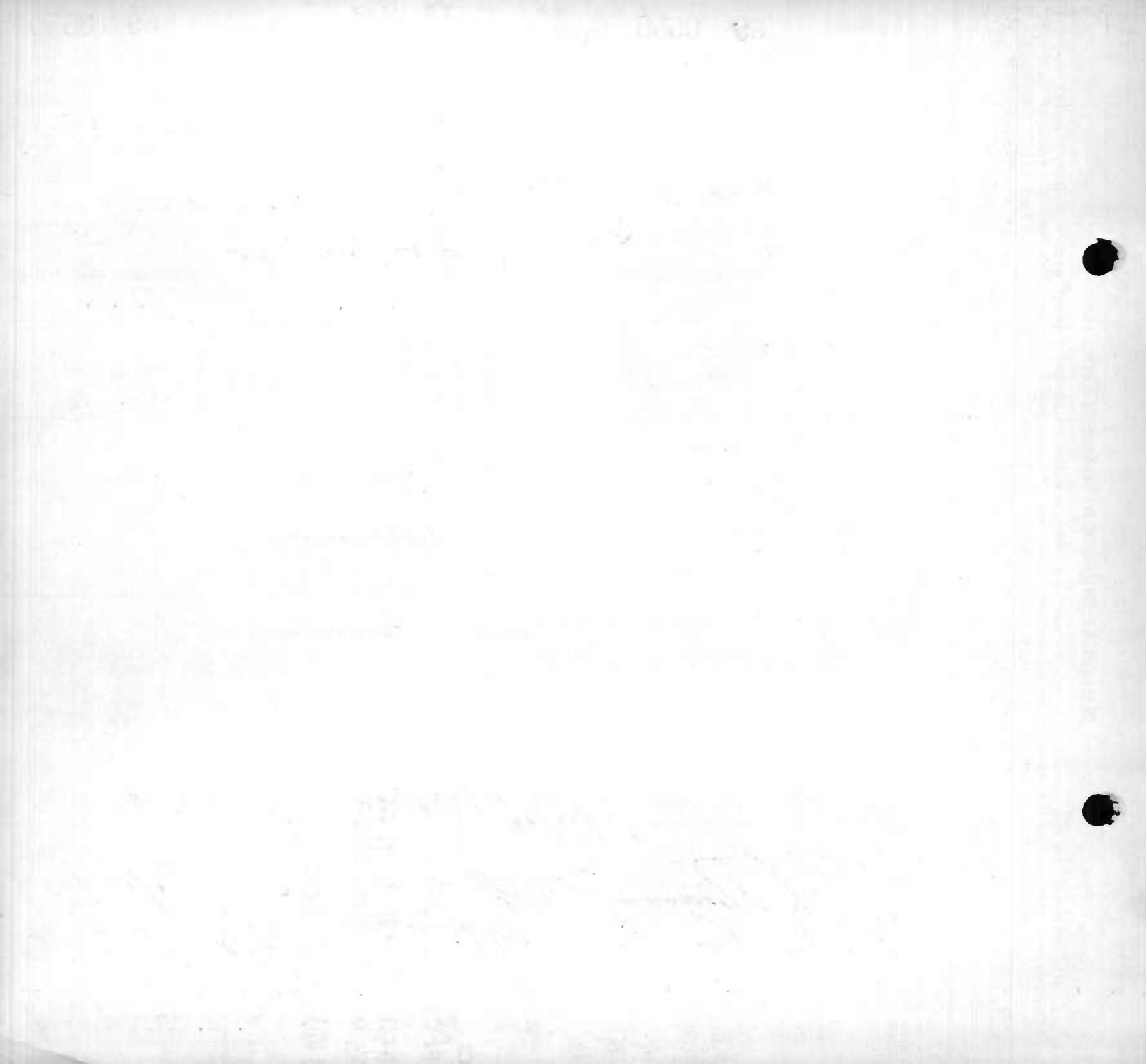




# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH											
Roane, Florence R.				1/17/69				5:11 A.M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)											
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE				B. COUNTY							
42 Sinai Hosp. of Balt.				Balt., Maryland.				15-10							
				C. CITY OR TOWN				D. INSIDE CITY LIMITS?							
				Balt.				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
				E. STREET AND NUMBER											
				4110 Rollins Ave. #07											
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.			
7		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12/14/1913		55							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Housewife								Balto, Md.				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME											
Williams Banks				Mary Weaver											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
								Lawrence Roane				4110 Rollins Ave			
18. 00891				CAUSE OF DEATH								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:											
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				Hypertension											
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:											
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Septicemia											
				(C) DUE TO, OR AS A CONSEQUENCE OF:											
				Tissue Necrosis											
II															
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).															
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
O															
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)											
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?											
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>													
22. I certify that (1) (this hospital) attended the deceased from 12/28/68 19 to 1/17/69 19				that (1) (we) last saw the deceased alive on 1/17/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.											
23A. SIGNATURE				23B. DATE SIGNED											
F. L. Goodman M.D.				1/17/69											
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS											
F. L. Goodman, M.D. Sinai Hosp. of Balt.															
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)									
Burial		1-20-69		Baltimore National Ceme.		Baltimore, Maryland									
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS									
JAN 20 1969		R. E. Farkner		Morton & Dyett F. H.		1701 Laurens St									



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>69 0661</b>	
BIRTH NO. <b>69 0661</b>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>GIOVANNA (JENNIE) PETTI</b>			2. DATE AND HOUR OF DEATH <b>JANUARY 17, 1969</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>3-01</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>00 1407 BANK ST</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>1407 BANK STREET</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-23-1898</b>	9. AGE (In years lost birthday) <b>71</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>ITALY</b>	
13. FATHER'S NAME <b>MICHAEL SPERAZELLA</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>JOSEPH PETTI 1407 BANK ST</b>
18. <b>486X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>Primum</b>			CAUSE OF DEATH <b>Primum</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 1968</b> to <b>1/17</b> 19 <b>69</b> , that (I) <del>was</del> lost saw the deceased alive on <b>1/16</b> 19 <b>69</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> <del>did</del> (did not) view the body after death.					
23A. SIGNATURE <b>Joseph R. Liberto M.D.</b>			23B. DATE SIGNED <b>1/17/69</b>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <b>JOSEPH R. LIBERTO, M.D.</b>			23D. ADDRESS <b>3502 Bank St Baltimore, Md.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-20-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>HOLY REDEEMER</b>	
				24D. LOCATION (City, town, or county) (State) <b>BALTIMORE</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>		25B. NAME OF REGISTRAR <b>R. E. F. F. F.</b>		25C. FUNERAL DIRECTOR <b>WEBER FUNERAL HOME 5311 EDWINSON AVE</b>	

12-10-61

X W F

12-10-61

1741

WIDE LIFE

MICHAEL SPEARHEAD

LIBRA

GREEN PATTI 1967 6000

12-10-61 1741 1741

WATER F. DEANAL HOME 1967 6000

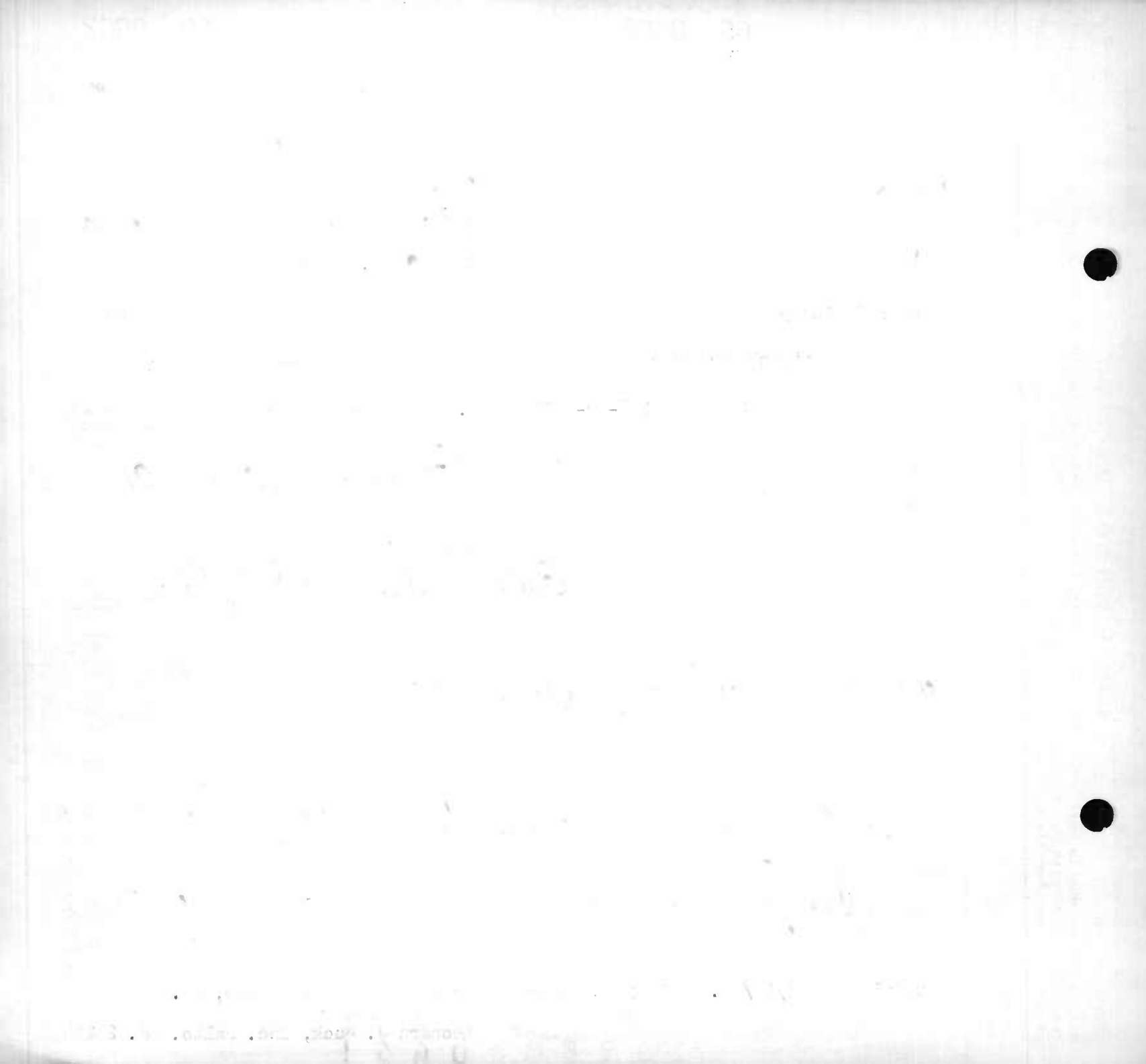
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

 REG. NO. **69 0662**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>STAFFORD, MICHAEL JOHN</b>		2. DATE AND HOUR OF DEATH <b>1.17.69 11:58 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>27-49</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>1908 HEATHFIELD RD.</b>					
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4.10.16</b>	9. AGE (In years last birthday) <b>52</b>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Engineer</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Patrick Stafford</b>			
14. MOTHER'S MAIDEN NAME <b>Mary Ann ?</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW2</b>			
16. SOCIAL SECURITY NO. <b>215-09-4632</b>		17. INFORMANT <b>Mrs. Catherine Stafford</b>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>I</b> <b>Carcinoma of Lung</b> <b>Apr. 1968</b> <b>Carcinoma of Lung</b> <b>Due to, or as a consequence of:</b> <b>Colon - Lambert Syndrome</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Apr. 1968</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>Apr. 1968</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma of Lung</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (if this hospital) attended the deceased from <b>1.16.1969</b> to <b>1.17.1969</b> that (I) (we) last saw the deceased alive on <b>1.17.1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Garvey H.P.</b>		23B. DATE SIGNED <b>1.17.69</b>		23C. PHYSICIAN'S NAME (Type) <b>GARVEY</b>	
23D. ADDRESS <b>UNIVERSITY HOSPITAL</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>1/20/69.</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Rodger Wilbur Hurley</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <b>1</b> Day <b>17</b> Year <b>1969</b> Estimated <input type="checkbox"/> Hour <b>2:30 PM</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33 Johns Hopkins Hospital</b>		3. DATE PRONOUNCED DEAD Month <b>1</b> Day <b>17</b> Year <b>1969</b> Hour <b>2:40 PM</b>	
6. SEX <b>M</b> 7. RACE <b>White</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>27-06</b>	
9. DATE OF BIRTH <b>Feb. 26, 1935.</b> 10. AGE (In years, last birthday) <b>33</b> 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
12. CITIZEN OF <b>USA</b>		E. STREET AND NUMBER <b>6231 Catalpha Road</b>	
13. FATHER'S NAME <b>Earle P. Hurley</b>		14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Vice President</b>	
14B. KIND OF BUSINESS OR INDUSTRY <b>Oil Co.</b>		15. MOTHER'S MAIDEN NAME <b>Elizabeth Strojcek</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>219-30-3668</b>	
18. INFORMANT <b>Mrs. Frances C. Hurley</b>		ADDRESS <b>(Same)</b>	
19. <b>E 918X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Asphyxia due to compression of chest</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>road</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>1001 W. Chester St. 7-03</b>		22D. TIME OF INJURY (APPROX.) <b>1 17 1969 2:30 PM</b>	
22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>shirt caught in drive shaft while working under vehicle.</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/21/69.</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Parkwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Tashy</b>	
25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		ADDRESS	

See also 153

Analysis  
of the  
material

Analysis  
of the  
material

See also 153-154 and 155-156

VALLEY VIEW

See also 153-154 and 155-156



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. **69 0664**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>CAROLINE ELLENBERGER</b>		2. DATE AND HOUR OF DEATH <b>JANUARY 18, 1969. 12:15 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>00 2809 Fleetwood Avenue</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>27-47</b>		
			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>2809 Fleetwood Avenue</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 27, 1871.</b>		9. AGE (In years last birthday) <b>97</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
13. FATHER'S NAME <b>Ernest Raab</b>			14. MOTHER'S MAIDEN NAME <b>Caroline Schilling</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-52-1175</b>		17. INFORMANT ADDRESS <b>Louise Dietzel 3020 Parkside Drive</b>	
18. <b>41213 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  <b>Arteriosclerotic heart disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Feb 18 1964</b> to <b>January 18 1969</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>January 18 1969</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>Edmund</b>				23B. DATE SIGNED <b>1/18/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Edward J. Alessi M.D.</b>				23D. ADDRESS <b>6217 Harford Road Balto. Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/21/69</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cem.</b>	
24D. LOCATION <b>Balto. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>			
25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>			

60 (Rev. 11-1-60) 11/18/60

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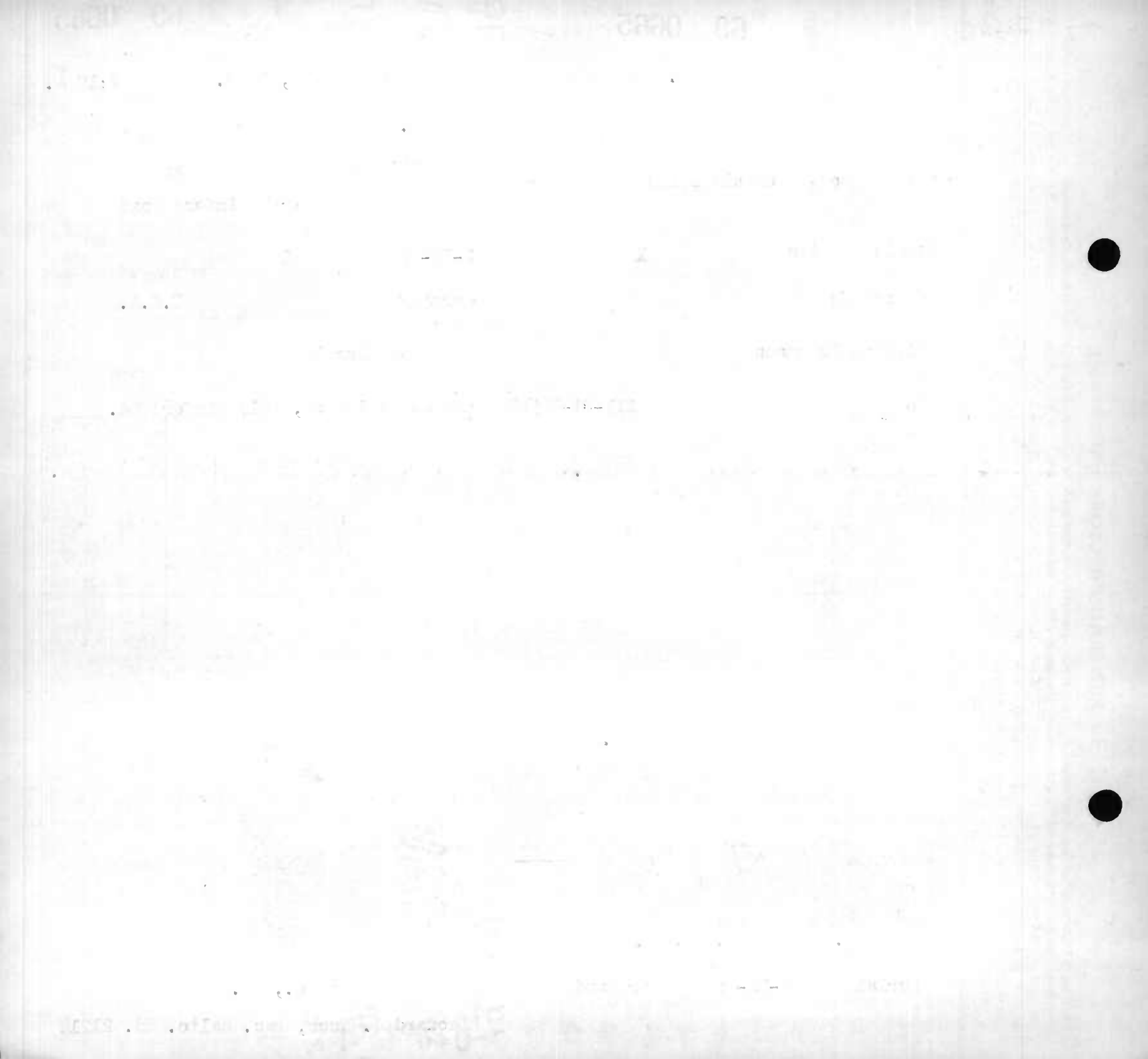
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 69 0665 CERTIFICATE OF DEATH

REG. NO. 69 0665

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		LOUISE A. ZIMMER		January 20, 1969. 2:10 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 90 Could Convalesarium			A. STATE Md. B. COUNTY 27-49		
5. SEX Female			6. RACE White		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 2-12-87		
9. AGE (In years lost birthday) 81			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		
11. BIRTHPLACE (State or foreign country) Germany			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Schumann			14. MOTHER'S MAIDEN NAME Agnes Bischof		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 217-01-38500		
17. INFORMANT Mary Hetherington, 1617 Winford Rd.			ADDRESS		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
I Carcinoma of left breast 3 yrs.					
II Arteriosclerotic cardiovascular disease Many years					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March, 1960 to 1/20/69		22B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
23A. SIGNATURE		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1-22-69		Moreland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 20 1969		Leonard J. Buck, Inc. Balto. Md. 21214			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0666

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

69 0666

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Adolph Meyer</b>		2. DATE AND HOUR OF DEATH <b>1-19-69</b> <b>2<sup>00</sup> P M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1933 E. 32nd St.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>9-06</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO E. STREET AND NUMBER <b>1933 E. 32nd St.</b>		
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-15-90</b>	9. AGE (In years last birthday) <b>78</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Owner</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Hardware Store</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Harry Meyer</b>			14. MOTHER'S MAIDEN NAME <b>Mary Reeve</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW 1</b>		16. SOCIAL SECURITY NO. <b>214-34-3002</b>		17. INFORMANT ADDRESS <b>Claire Graueh 1618 Ingram Rd</b>	
18. CAUSE OF DEATH <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE</b> <i>Coronary occlusion</i> DUE TO, OR AS A CONSEQUENCE OF: <b>(B)</b> <i>Arterio sclerosis</i> DUE TO, OR AS A CONSEQUENCE OF: <b>(C)</b> <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Emphysema</i>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1950</b> to <b>Jan 19 1969</b> , that (I) (we) last saw the deceased alive on <b>Jan 3 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <i>Theodore J. Graziano</i> DEGREE				23B. DATE SIGNED <b>1/20/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Theodore J. Graziano, M.D.</b> DEGREE				23D. ADDRESS <b>1654 Belvedere Ave. 21212</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/23/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

69 0667

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

WILLIAM O. RATCLIFFE, Jr.

2. DATE AND HOUR OF DEATH

JANUARY 18 1969 9:06 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

37 MERCY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission)

A. STATE

B. COUNTY

MD.

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

100 E. 32nd STREET

5. SEX

M

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

12-12-1899 69

9. AGE (in years last birthday)

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Ret. Civil Service

10B. KIND OF BUSINESS OR INDUSTRY

Air Force

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MD.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

WILLIAM O. RATCLIFFE, Sr.

14. MOTHER'S MAIDEN NAME

MARGARET HANNIE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

212-05-6973

17. INFORMANT

Beatrice Ratcliffe, 100 E. 32nd St.

18.

162.1 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

PNEUMONIA

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

FEW DAYS

(B)

GENERAL DEBILITY

DUE TO, OR AS A CONSEQUENCE OF:

(C)

CA OF LUNG & METASTASIS TO

BONE & BRAIN

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from DEC. 15 19 68 to JAN. 18 19 69 that (I) (we) last saw the deceased alive on Jan. 18 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Ponciano V. SALUD M.D.

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

Jan. 18, 1969

23C. PHYSICIAN'S NAME (Type)

Ponciano V. SALUD M.D.

23D. ADDRESS

MERCY HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1-22-69

24C. NAME of CEMETERY or CREMATORY

Loudon Pk.

24D. LOCATION

Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 20 1969

25B. NAME OF REGISTRAR

Robert E. [Signature]

25C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc., 5305 Harford Rd.

ADDRESS

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0668

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

69 0668

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Josephine Fields</b>		2. DATE AND HOUR OF DEATH <b>1-19-69 6: A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>48 Maryland Gen. Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Baltimore</b> B. COUNTY <b>Maryland</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1919 Woodbourne Ave.</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>01 8-12-1908</b>	9. AGE (In years last birthday) <b>67</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Balto.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Joseph Serio</b>			
14. MOTHER'S MAIDEN NAME <b>Marie Jeppi</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>211-40-3404</b>		17. INFORMANT <b>Marie Farrell</b>			
18. <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardio-respiratory Arrest</b> (B) <b>Atherosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1-3-1969</b> to <b>1-19-1969</b> , that (I) (we) last saw the deceased alive on <b>1-19-1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>D. C. Gomez, M.D.</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>D. C. Gomez, M.D.</b>				23D. ADDRESS <b>Balto, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-23-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer</b>	
24D. LOCATION (City, town, or county) <b>Balto, Md.</b>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>	
25D. ADDRESS					

100

along thread

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 0669

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

JOHN W. RICH

2. DATE  
OF  
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

January 16, 1969

6:20 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(If not in hospital or institution, give street  
address or location)

SINAI HOSPITAL (DOA)

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

January 16, 1969

6:20 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

14-02

6. SEX

Male

7. RACE

Negro

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

2/16/02

10. AGE (In years  
lost birthday)

66

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1737 Druid Hill Avenue

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF

U.S.A.

13. FATHER'S NAME

John W. Rich

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Annie Webb

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

218-14-8352

18. INFORMANT

ADDRESS

Ethel P. Rich, 1737 Druid Hill Ave.

19.

441.01

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Hemopericardium

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) Dissecting Aneurysm of aorta (Marfan's)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/17/69

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1/20/69

24C. NAME OF CEMETERY or CREMATORY

Arbutus Mem. Park

24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JAN 20 1969

25B. NAME OF REGISTRAR

Robert E. Johnson

25C. FUNERAL DIRECTOR

ADDRESS

Charles R. Law, 802 Madison Ave.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 0670
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Florida Lashley</i>		2. DATE AND HOUR OF DEATH <i>1-15-69 4:00 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>George Washington NURS. Home</i>			A. STATE <i>MARYLAND</i>		B. COUNTY <i>6-01</i>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
90			E. STREET AND NUMBER <i>207 N. CURLEY ST</i>		
5. SEX <i>Female</i>	6. RACE <i>NEGRO</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/15/02</i>	9. AGE (In years lost years) <i>66</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>WARFIELD, VA</i>	
13. FATHER'S NAME <i>Brice Noble</i>		14. MOTHER'S MAIDEN NAME <i>LENA DAVIS</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>214-54-3454</i>		17. INFORMANT <i>CHART # 821 607 PENNA AVE.</i>	
18. <i>47 IX I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Lobar Pneumonia</i> (B) <i>Acute Influenza</i> (C) <i>Post CVA - Left Hemiplegia</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>2 weeks</i> <i>Unknown</i> <i>Unknown</i>		
MEDICAL CERTIFICATION			II		
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1/25 19 67</i> to <i>1/15 19 69</i> , that (I) (we) last saw the deceased alive on <i>1/4 19 69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>E.E. Holt M.D.</i>			23B. DATE SIGNED <i>1/16/69</i>		
23C. PHYSICIAN'S NAME (Type) <i>E.E. Holt M.D.</i>			23D. ADDRESS <i>3715 Liberty Hgts. Ave.</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-18-69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn</i>	
24D. LOCATION <i>Baltimore, Maryland 2120</i>					
25A. DATE RECEIVED BY HEALTH DEPT. <i>JAN 20 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber</i>		25C. FUNERAL DIRECTOR <i>Charles R. Law</i>	
ADDRESS <i>802 Madison Ave.</i>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 69 0671 CERTIFICATE OF DEATH

REG. NO. 69 0671

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>E LLEN L. BUCHANAN</b>		2. DATE AND HOUR OF DEATH <b>16 JAN 1969 3:30 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Howard Co.</b> <b>63-00</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY OF MARYLAND HOSPITAL</b>			C. CITY OR TOWN <b>WOODSTOCK</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER		
5. SEX <b>FEMALE</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/31/12</b>	9. AGE (In years last birthday) <b>56</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Woodstock Maryland</b>	
13. FATHER'S NAME <b>Gabriel Bennett</b>			14. MOTHER'S MAIDEN NAME <b>Emma Jones</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Webbley Buchanan, Woodstock, Maryland</b>	
18. <b>430X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary embolus</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 MIN.</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Cerebral atrophy etiology undetermined.</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <b>3 JAN 19 67</b> to <b>16 JAN 19 67</b> that (I) (we) last saw the deceased alive on <b>16 JAN 19 67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Solomon D. Robbins M.D.</b>			23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>SOLOMON D. ROBBINS</b>
23D. ADDRESS <b>MD UNIVERSITY OF MD. HOSPITAL, BALTIMORE MD</b>			23E. DEGREE		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-21-69</b>		24C. NAME of CEMETERY or CREMATORY <b>St. Alphansus</b>	
24D. LOCATION <b>Woodstock, Maryland</b>		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>		25B. NAME OF REGISTRAR <b>Charles R. Law</b>		25C. FUNERAL DIRECTOR <b>Charles R. Law, 802 Madison Ave.</b>	
25D. ADDRESS		25E. (City, town, or county) (State)			

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Handwritten text, possibly a description or note.

Handwritten text, possibly a signature or name.

Handwritten text, possibly a footer or concluding note.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 0672

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

RUSSELL JONES

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

January 15, 1969

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

00 6 South Caroline Street

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

January 15, 1969

6:35 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

3-01

6. SEX

Male

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

Nov. 9, 1919

10. AGE (In years  
last birthday)

49

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

6 South Caroline Street

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Jones

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Levia

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Johnson Funeral Home, Va.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Fatty metamorphosis of liver

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A)

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

January 16, 1969

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1-19-69

24C. NAME OF CEMETERY or CREMATORY

Mt. Zion Church cemetery, Advancemills, Va.

24D. LOCATION (City, town, or county)

(State)

25A. DATE RECEIVED BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Johnson Funeral Home, 203 8th St. N.W.

Charlottesville, Va.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

WILLIAM WALL THORNTON

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☒

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

January 14, 1969

1:55 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

8-43

6. SEX

male

7. RACE

negro

B. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

July 21, 1939

10. AGE (In years  
last birthday)

29

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

2823 E. Federal Street

11. BIRTHPLACE (State or foreign country)

Balto., Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Eustace Thornton

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Effie Wall

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Effie Thornton 2823 E. Federal St.

19. 304.91

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

Narcotic Overdose

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II  
ANTECEDENT CAUSESDISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/14/69

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1-18-69

24C. NAME of CEMETERY or CREMATORY

Mt Auburn Cemetery

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

25A. DATE RECEIVED BY HEALTH DEPT

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Wm C March 928 E. North Ave.

PA 2020

PA 2020

PA 2020

PA 2020

PA 2020

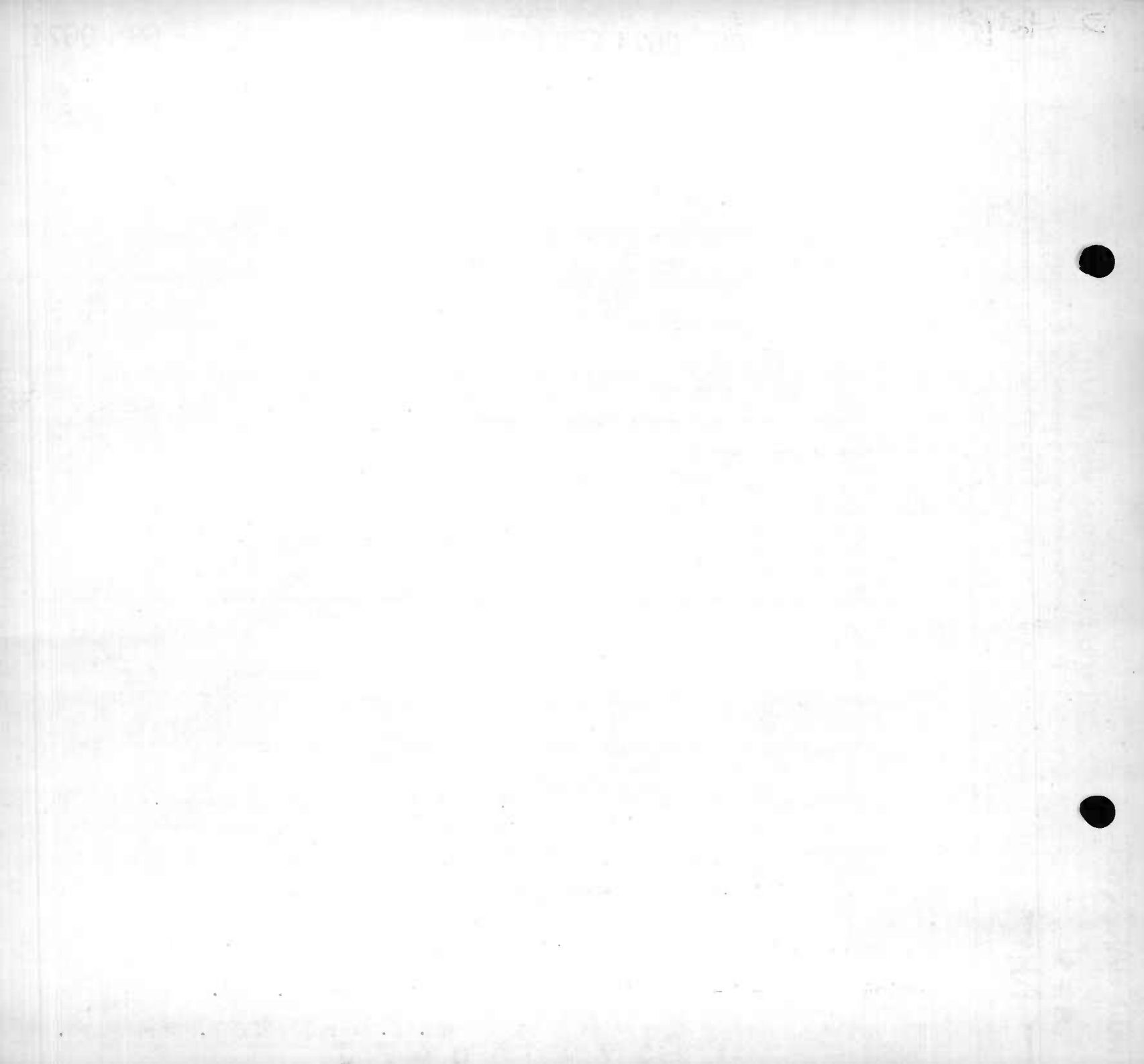
PA 2020

PA 2020

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">69 0674</span>
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">EUCLID TO PAUL</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">January 16/1969 7:45 P.M.</span>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">Union Memorial Hospital</span>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) <b>A. STATE</b> <span style="font-size: 1.2em;">Maryland</span> <b>B. COUNTY</b> <span style="font-size: 1.2em;">9-04</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">640 E. 29<sup>th</sup> Street</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">male</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">white</span>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">1-16/1912</span>	<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">56</span> <b>If Under 1 Yr.</b> Months: <b>If Under 24 Hrs.</b> Days: <b>Hours:</b> <b>Min.</b>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Foreman</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Railroad</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">American</span>		<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Samuel Euclid</span>		
<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Theresa</span>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		
<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Myrtle Lee Paul</span> <b>ADDRESS</b> <span style="font-size: 1.2em;">640 E 29<sup>th</sup> St.</span>		
<b>18. CAUSE OF DEATH</b>				
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>(A) IMMEDIATE CAUSE</b> <span style="font-size: 1.2em;">respiratory arrest</span> DUE TO, OR AS A CONSEQUENCE OF:  <b>(B) Cardiovascular accident</b> DUE TO, OR AS A CONSEQUENCE OF:  <b>(C)</b>		
<b>II</b>				
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>				
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">1-16-69</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <span style="font-size: 1.2em;">No</span>		<b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">No</span>
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.) <b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>		
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">January 10</span> <b>19</b> <span style="font-size: 1.2em;">69</span> <b>to</b> <span style="font-size: 1.2em;">January 16</span> <b>19</b> <span style="font-size: 1.2em;">69</span> , <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">January 16</span> <b>19</b> <span style="font-size: 1.2em;">69</span> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Eugene Ellenbogen MD</span>		<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">1-16-1969</span>		<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">Eugene Ellenbogen MD</span>
<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">Union Memorial Hospital</span>		<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.2em;">Burial</span>		
<b>24B. DATE</b> <span style="font-size: 1.2em;">1-20-69</span>		<b>24C. NAME of CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Holy Cross Cemetery</span>		<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Balto., Md.</span>
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">JAN 20 1969</span>		<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Taylor</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">Wm. C. March</span> <b>ADDRESS</b> <span style="font-size: 1.2em;">928 E. North Ave.</span>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-4039			
1. NAME OF DECEASED (Type or Print) <u>Harry Stevens</u>				2. DATE AND HOUR OF DEATH <u>1-18-69</u> <u>2:40 A.M.</u>				69 0675			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION <u>46</u> <u>Lutheran Hospital of Maryland</u>				A. STATE <u>Maryland</u>				B. COUNTY <u>25-53</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>Baltimore</u>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <u>male</u>				6. RACE <u>white</u>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>12-28-97</u>				9. AGE (In years lost birthday) <u>71</u>				If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>CEMENT FINISHER</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>American</u>				13. FATHER'S NAME <u>HARRY STEVENS</u>				14. MOTHER'S MAIDEN NAME <u>MARY DECK</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>212-10-1351-A</u>				17. INFORMANT <u>wife</u>			
18. <u>3 15 0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>pneumonia &amp; pleural effusion 1WK</u> (B) <u>Silicosis</u> DUE TO, OR AS A CONSEQUENCE OF: <u>7 Ms</u> (C) <u>Anemia &amp; Uremia</u> <u>1WK</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <u>NO</u>			
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 15</u> 19 <u>69</u> to <u>Jan 18</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Jan 18</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Junja Chig</u>				23B. DATE SIGNED <u>Jan 18 '69</u>							
23C. PHYSICIAN'S NAME (Type) <u>Paul Schonfeld, M.D.</u>				23D. ADDRESS <u>Lutheran Hospital of Maryland</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>				24B. DATE <u>1-21-69</u>				24C. NAME OF CEMETERY or CREMATORY <u>LODON PARK CEMETERY</u>			
24D. LOCATION <u>BALTIMORE, MARYLAND</u>											
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1969</u>				25B. NAME OF REGISTRAR <u>WALTERS, FAN'L HOME</u>				25C. FUNERAL DIRECTOR <u>PRATT+STRICKER</u>			

DATA

00000000

WARY DECK

HARRY STEVENS

00000000

00000000

00000000



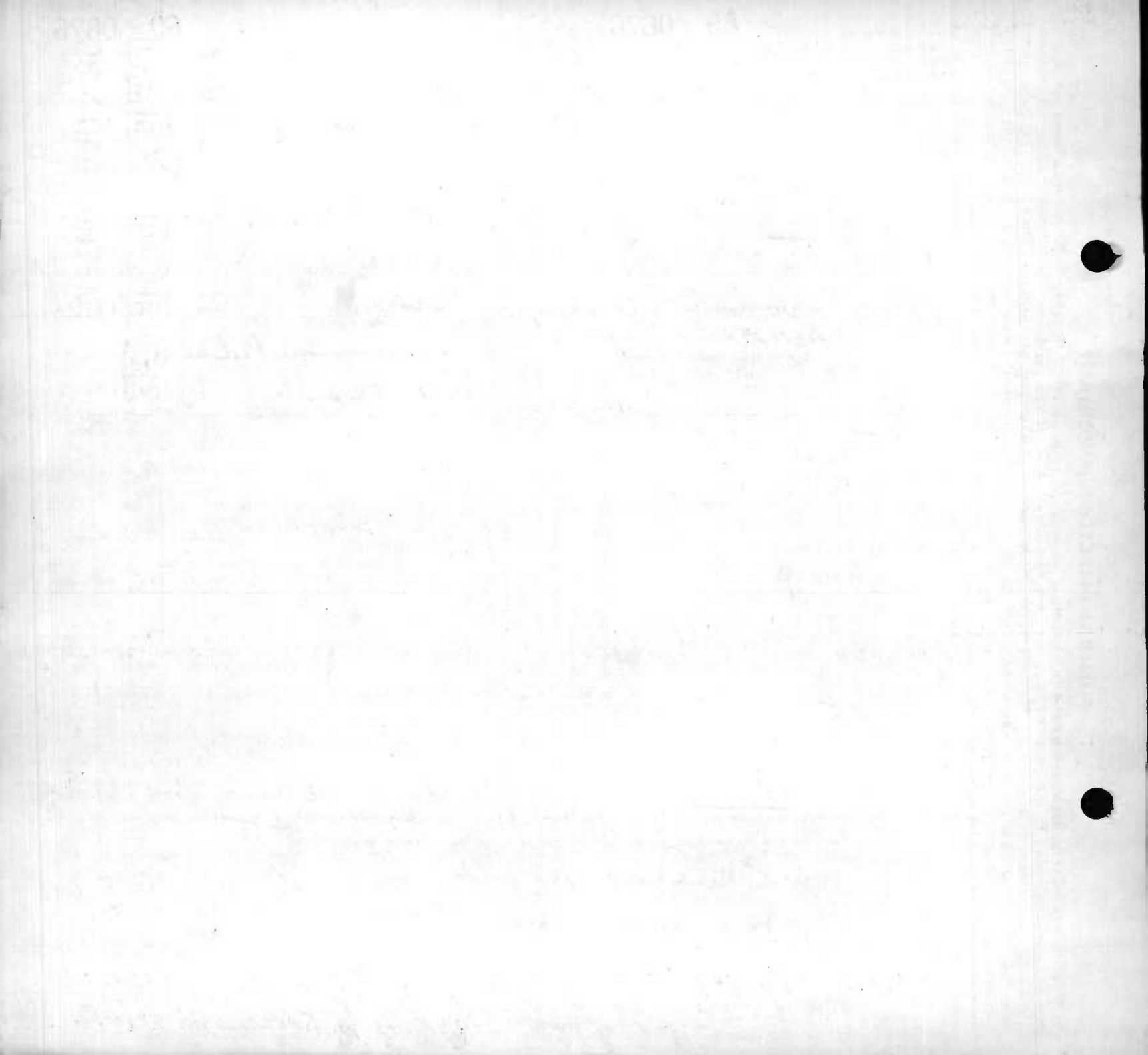
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0676 BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 69 0676

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MICHAEL D. EWANCIO (IWANCIO)</b>		2. DATE AND HOUR OF DEATH <b>1-18-69 10:45 PM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1-02</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>35</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>CHURCH HOME &amp; Hosp</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED BALD. THUR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SELF EMPLOYED</b>		8. DATE OF BIRTH <b>8-27-88</b> 9. AGE (In years last birthday) <b>80</b>	
11. BIRTHPLACE (State or foreign country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>		13. FATHER'S NAME <b>KONSTANTY IWANCIO</b>	
14. MOTHER'S MAIDEN NAME <b>ELIZABETH PULAGIA KUZAN</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-07-4681</b>	
17. INFORMANT <b>ANNA EWANCIO WIFE</b>		ADDRESS <b>631 S. Kenwood Ave 24 BALT. MD.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. <b>412.41</b> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>ASPIRATION PNEUMONIA</b>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>CONGESTIVE HEART FAILURE, ASCVD.</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1-14</b> 19 <b>69</b> to <b>1-18</b> 19 <b>69</b> , that (I) (we) lost saw the deceased alive on <b>1-18</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b> M.D. DEGREE				23B. DATE SIGNED <b>1-18-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOSE MIER, JR. M.D.</b> DEGREE				23D. ADDRESS <b>100 W. BROADWAY BALT. MD 21231</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1/22/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>ST. STANISLAUS CEMETERY</b>	
24D. LOCATION (City, town, or county) <b>BALTIMORE</b>		24E. STATE <b>MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1969</b>	
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>RAYMOND B. KACZOROWSKI</b>		ADDRESS <b>2525 FLEET ST.</b>	



FUNERAL DIRECTOR: IMPORTANT

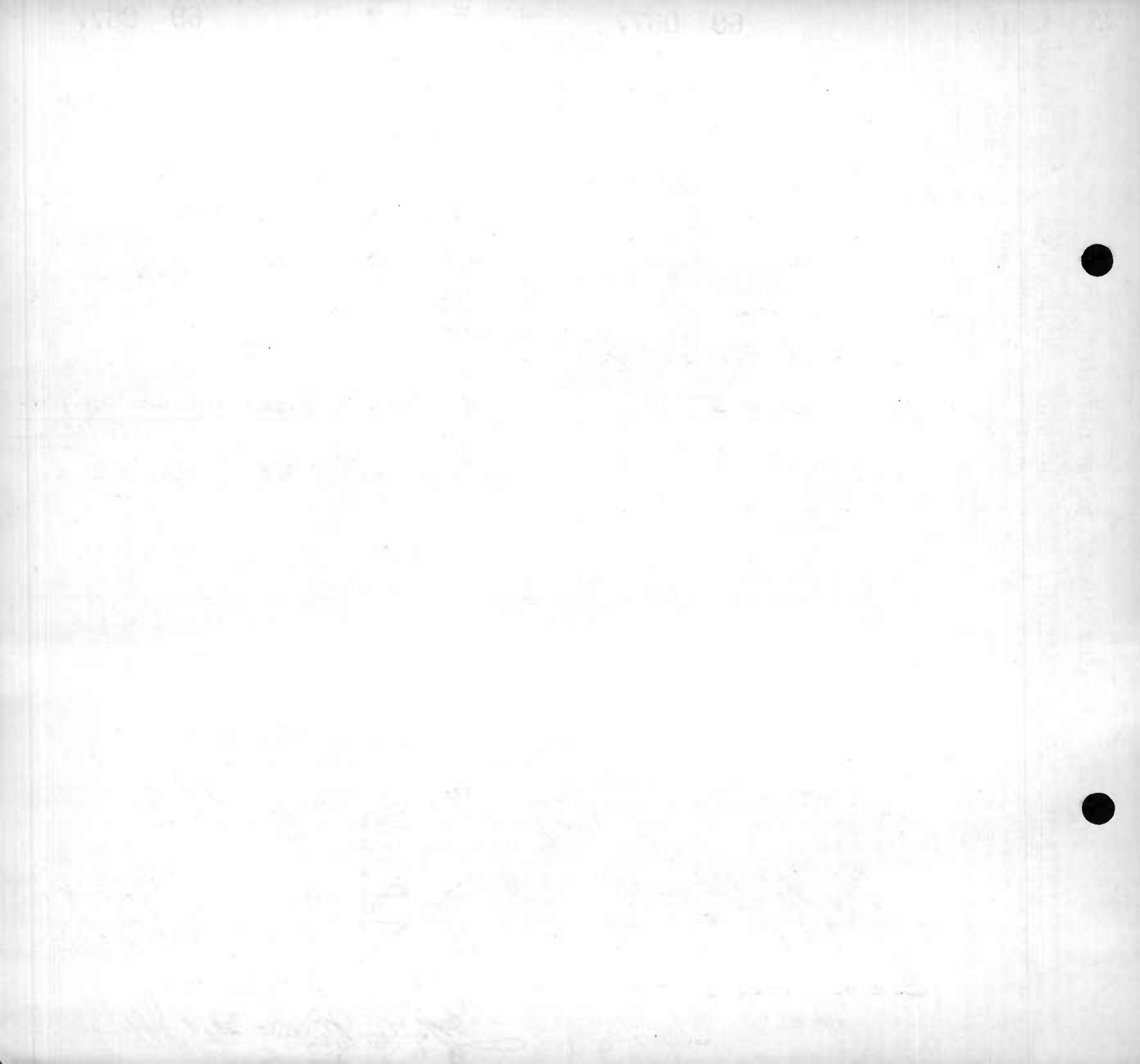
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0677

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 0677

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>JOHN JOSEPH MARLEY, JR.</i>		2. DATE AND HOUR OF DEATH <i>1-19-69</i>		M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <i>1118 SHERWOOD AVE.</i> <i>00</i>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <i>MARYLAND</i>		
				B. COUNTY <i>27-48</i>				
C. CITY OR TOWN <i>BALTIMORE</i>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
E. STREET AND NUMBER <i>1118 SHERWOOD AVE.</i>								
5. SEX <i>M</i>	6. RACE <i>N</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>6-24-1917</i>	9. AGE (In years last birthday) <i>51</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>STEEL FABRICATOR</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>PENNSYLVANIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>JOHN J. MARLEY, SR.</i>				14. MOTHER'S MAIDEN NAME <i>CATHERINE THOMAS</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>YES</i> <i>W.W.II</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Marie F. Marley - 1118 Sherwood Ave.</i>		ADDRESS		
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Massive Myocardial Infarction</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (1) (this hospital) attended the deceased from <i>9/25</i> <i>1968</i> to <i>1/19</i> <i>1969</i> , that (1) (we) lost saw the deceased alive on <i>1/6/69</i> <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.								
23A. SIGNATURE <i>W.M. Smith</i>				23B. DATE SIGNED <i>1/20/69</i>				
23C. PHYSICIAN'S NAME (Type) <i>W.M. Smith M.D.</i>				23D. ADDRESS <i>6305 Blanche Blvd. Md.</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>1-22-69</i>		24C. NAME OF CEMETERY or CREMATORY <i>DUKANEY VALLEY Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>BALTO., MD.</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 21 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Garley Miller - 2334 Jefferson St.</i>		ADDRESS		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

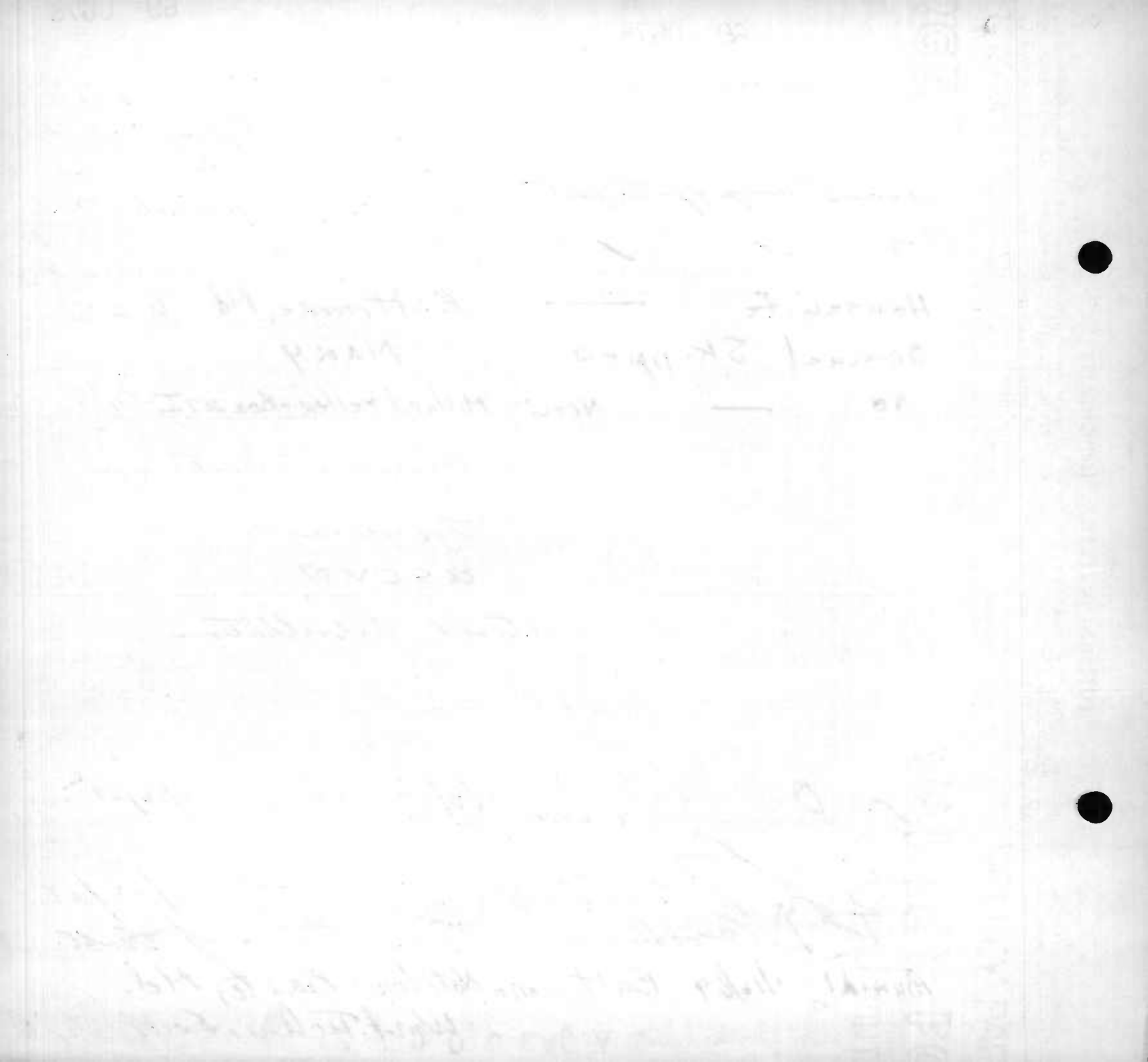
## BALTIMORE CITY HEALTH DEPARTMENT

# 69 0678 CERTIFICATE OF DEATH

REG. NO.

69 0678

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Sorensen, Anna</i>		2. DATE AND HOUR OF DEATH <i>2:20 PM 1/12/69</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Carroll</i>		56-00	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Sinai Hosp. of Balt.</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Sykesville</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <i>Box 2071 Sykesville, Md.</i>			
S. SEX <i>7</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/3/91</i>	9. AGE (In years last birthday) <i>77</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>	
13. FATHER'S NAME <i>Samuel Skipper</i>		14. MOTHER'S MAIDEN NAME <i>Mary</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Millard Keller - Box 2071 - Sykesville</i>	
18. <i>412.41</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pneumonia &amp; Septicemia</i> (B) <i>Out Edema</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>ASCVD</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Atrial Fibrillation</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1/11/69</i> 19 to <i>1/12/69</i> 19 that (I) (we) last saw the deceased alive on <i>2:20 PM 1/12/69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i>		23B. DATE SIGNED <i>1/12/69</i>		23C. PHYSICIAN'S NAME (Type) <i>L. Goodman</i>	
23D. ADDRESS <i>Sinai Hosp. of Balt.</i>		23E. DEGREE			
24A. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/16/69</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Baltimore Nat'l Cem</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 21 1969</i>			
25B. NAME OF REGISTRAR <i>[Signature]</i>		25C. FUNERAL DIRECTOR <i>Wm. F. Helmer, Sr. Balt, Md.</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">69 0679</span>	
BIRTH NO.		69 0679		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>HAROLD RAYMOND BENJAMIN</b>			2. DATE AND HOUR OF DEATH <b>JAN. 12, 1969 10:30 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Prince Georges 66-00</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>38 UNIVERSITY OF MARYLAND HOSPITAL</b>			C. CITY OR TOWN <b>LAUREL</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>9206 ETHEN COURT</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/27/93</b>	9. AGE (In years lost birthday) <b>75 YES</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PROFESSOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>EDUCATION</b>		11. BIRTHPLACE (State or foreign country) <b>WISCONSIN</b>	
13. FATHER'S NAME <b>HERBERT S. BENJAMIN</b>			14. MOTHER'S MAIDEN NAME <b>HARRIETT LOCKE</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>PATIENT (ON ADMISSION)</b>	
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>		(A) IMMEDIATE CAUSE <b>METASTASIS TO MEDIASTINUM</b> DUE TO, OR AS A CONSEQUENCE OF: <b>METASTASIS TO BRAIN + LIVER</b> <b>CARCINOMA OF THE STOMACH</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>2 NO</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>-</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>-</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>-</b>	
21D. TIME OF INJURY (APPROX.) <b>-</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>-</b>	
22. I certify that (1) (this hospital) attended the deceased from <b>12/27</b> 19 <b>68</b> to <b>1/12</b> 19 <b>69</b> , that (2) (we) last saw the deceased alive on <b>1/12</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Margaret L. Bauman M.D.</b>				23B. DATE SIGNED <b>1/12/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>MARGARET L. BAUMAN M.D.</b>				23D. ADDRESS <b>UNIVERSITY OF MARYLAND HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/18/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cem.</b>	
24D. LOCATION <b>NASHVILLE TENN.</b>		24E. NAME OF REGISTRAR <b>Robert E. Fagan</b>		24F. FUNERAL DIRECTOR <b>James J. H.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fagan</b>		25C. FUNERAL DIRECTOR <b>James J. H.</b>	



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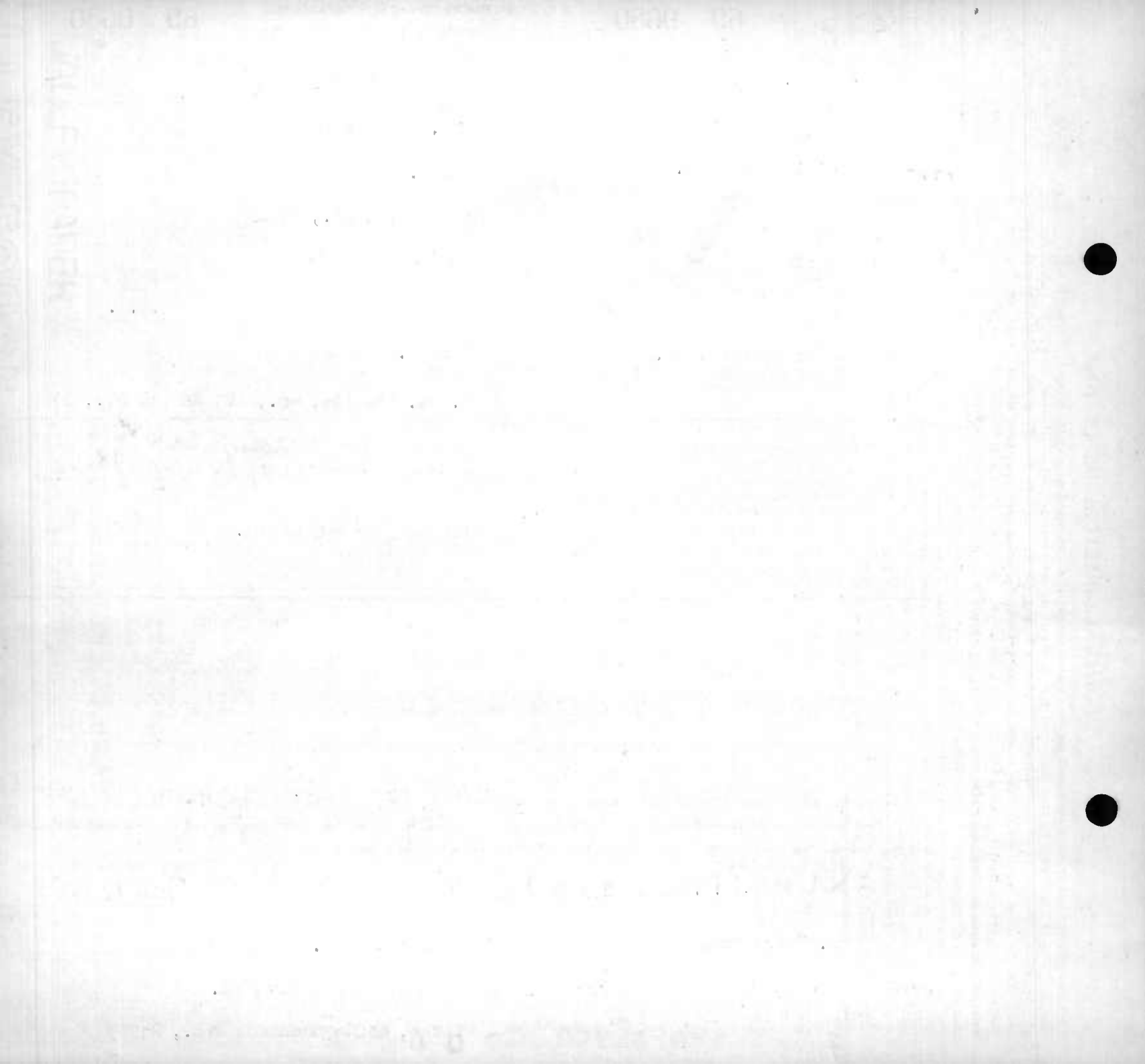
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**FUNERAL DIRECTOR: IMPORTANT**

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>69 0680</b>																																																			
<div style="display: flex; justify-content: space-between;"> <div> <b>1-623</b>  <b>69 0680</b>  <b>CERTIFICATE OF DEATH</b> </div> <div> <b>1</b>  <b>1</b> </div> </div>																																																							
<b>1. NAME OF DECEASED</b> (Type or Print) <b>June L. Trostle</b>			<b>2. DATE AND HOUR OF DEATH</b> <b>1/17/69</b>																																																				
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2501 Ashton St.</b>			<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> <b>20-05</b> <b>C. CITY OR TOWN</b> <b>Balto.</b> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <b>2501 Ashton St., 21223</b>																																																				
<b>5. SEX</b> <b>Female</b>	<b>6. RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>6/15/28</b>	<b>9. AGE</b> (In years last birthday) <b>40</b>	If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min. _____																																																		
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>																																																			
<b>13. FATHER'S NAME</b> <b>Late Roland Peacock, Sr.</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary H. Vogelsang</b>																																																				
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>	<b>17. INFORMANT</b> <b>Mr. Wm. Trostle, Jr., 2501 Ashton St., 21223</b>																																																				
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td rowspan="3" style="width: 15%; vertical-align: middle; text-align: center;"><b>MEDICAL CERTIFICATION</b></td> <td colspan="2" style="width: 45%;"> <b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>                      (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)   <b>CAUSE OF DEATH</b>                      (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  <i>Metastatic dissemination of the cancer of the lung</i>                      (B) <i>Carcinoma of the lung</i>                      (C) _____                 </td> <td style="width: 40%;"> <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>  <i>Hours</i>  <i>months</i> </td> </tr> <tr> <td colspan="2"> <b>II</b>                      OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                      _____                 </td> </tr> <tr> <td colspan="2"> <b>19A. DATE OF OPERATION</b>  <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>  <b>20A. AUTOPSY?</b> (Yes or No)  <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> </td> </tr> <tr> <td colspan="2"> <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/> </td> <td colspan="2"> <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)                 </td> <td colspan="2"> <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)                 </td> </tr> <tr> <td colspan="2"> <b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)                      (APPROX.)                 </td> <td colspan="2"> <b>21E. INJURY OCCURRED</b>                      White At Work <input type="checkbox"/> Not White At Work <input checked="" type="checkbox"/> </td> <td colspan="2"> <b>21F. HOW DID INJURY OCCUR?</b> </td> </tr> <tr> <td colspan="6"> <b>22. I certify that (I) (this hospital) attended the deceased from</b> <i>May 16 1968</i> <b>to</b> <i>Jan. 17 1969</i> <b>that (I) (we) last saw the deceased alive on</b> <i>Jan. 17 1969</i> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b> </td> </tr> <tr> <td colspan="3"> <b>23A. SIGNATURE</b>  <i>Henry Armnas</i> </td> <td colspan="2"> <b>23B. DATE SIGNED</b>  <i>Jan. 18, 1969</i> </td> <td> <b>23C. PHYSICIAN'S NAME</b> (Type)  <b>Dr. Henry Armnas</b> </td> </tr> <tr> <td colspan="3"> <b>23D. ADDRESS</b>  <b>1934 Wilkens Ave.</b> </td> <td colspan="3"> <b>24A. BURIAL CREMATION, REMOVAL</b> (Specify)  <b>Burial</b> </td> </tr> <tr> <td colspan="2"> <b>24B. DATE</b>  <b>1/21/69</b> </td> <td colspan="2"> <b>24C. NAME OF CEMETERY or CREMATORY</b>  <b>Baltimore National Cemetery</b> </td> <td colspan="2"> <b>24D. LOCATION</b> (City, town, or county) (State)  <b>Baltimore, Md.</b> </td> </tr> <tr> <td colspan="2"> <b>25A. DATE RECEIVED BY HEALTH DEPT.</b>  <b>JAN 21 1969</b> </td> <td colspan="2"> <b>25B. NAME OF REGISTRAR</b>  <i>Robert E. Johnson</i> </td> <td colspan="2"> <b>25C. FUNERAL DIRECTOR</b> <b>Witzke, 4101 Edmondson Ave., 21229</b> </td> </tr> </table>						<b>MEDICAL CERTIFICATION</b>	<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Metastatic dissemination of the cancer of the lung</i> (B) <i>Carcinoma of the lung</i> (C) _____		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <i>Hours</i> <i>months</i>	<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____		<b>19A. DATE OF OPERATION</b> <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>20A. AUTOPSY?</b> (Yes or No) <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> White At Work <input type="checkbox"/> Not White At Work <input checked="" type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>		<b>22. I certify that (I) (this hospital) attended the deceased from</b> <i>May 16 1968</i> <b>to</b> <i>Jan. 17 1969</i> <b>that (I) (we) last saw the deceased alive on</b> <i>Jan. 17 1969</i> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>						<b>23A. SIGNATURE</b> <i>Henry Armnas</i>			<b>23B. DATE SIGNED</b> <i>Jan. 18, 1969</i>		<b>23C. PHYSICIAN'S NAME</b> (Type) <b>Dr. Henry Armnas</b>	<b>23D. ADDRESS</b> <b>1934 Wilkens Ave.</b>			<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b>			<b>24B. DATE</b> <b>1/21/69</b>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>Baltimore National Cemetery</b>		<b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Md.</b>		<b>25A. DATE RECEIVED BY HEALTH DEPT.</b> <b>JAN 21 1969</b>		<b>25B. NAME OF REGISTRAR</b> <i>Robert E. Johnson</i>		<b>25C. FUNERAL DIRECTOR</b> <b>Witzke, 4101 Edmondson Ave., 21229</b>	
<b>MEDICAL CERTIFICATION</b>	<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Metastatic dissemination of the cancer of the lung</i> (B) <i>Carcinoma of the lung</i> (C) _____		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <i>Hours</i> <i>months</i>																																																				
	<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____																																																						
	<b>19A. DATE OF OPERATION</b> <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>20A. AUTOPSY?</b> (Yes or No) <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>																																																						
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)																																																			
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> White At Work <input type="checkbox"/> Not White At Work <input checked="" type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>																																																			
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <i>May 16 1968</i> <b>to</b> <i>Jan. 17 1969</i> <b>that (I) (we) last saw the deceased alive on</b> <i>Jan. 17 1969</i> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>																																																							
<b>23A. SIGNATURE</b> <i>Henry Armnas</i>			<b>23B. DATE SIGNED</b> <i>Jan. 18, 1969</i>		<b>23C. PHYSICIAN'S NAME</b> (Type) <b>Dr. Henry Armnas</b>																																																		
<b>23D. ADDRESS</b> <b>1934 Wilkens Ave.</b>			<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b>																																																				
<b>24B. DATE</b> <b>1/21/69</b>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>Baltimore National Cemetery</b>		<b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Md.</b>																																																			
<b>25A. DATE RECEIVED BY HEALTH DEPT.</b> <b>JAN 21 1969</b>		<b>25B. NAME OF REGISTRAR</b> <i>Robert E. Johnson</i>		<b>25C. FUNERAL DIRECTOR</b> <b>Witzke, 4101 Edmondson Ave., 21229</b>																																																			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
69 0681				69 0681	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Fowlkes, Eugene		1/19/69 5:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital			A. STATE B. COUNTY Maryland Baltimore		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 2817 E. Federal St.		
5. SEX Male	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/27/15	9. AGE (In years last birthday) 53	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY KOPPEARS CO.		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME SAM FOWLKES		14. MOTHER'S MAIDEN NAME KATE OLIVER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 227-143810		17. INFORMANT Cammie Fowlkes 2817 E. Federal St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Disease or condition directly leading to death: Aspiration			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CVA			DUE TO, OR AS A CONSEQUENCE OF: 3 days		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Hypertensive cardiovascular disease many yrs					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/19 1969 to 1/19 1969 that (I) (we) lost saw the deceased alive on 1/19 1969 and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. S. Atkinson, MD				23B. DATE SIGNED 1/19/69	
23C. PHYSICIAN'S NAME (Type) J. S. Atkinson, MD				23D. ADDRESS JHH	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-24-69		24C. NAME of CEMETERY or CREMATORY PRIVATE	
24D. LOCATION (City, town, or county) (State) CREWE VIRGINIA		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR JOSEPH KNIGHT		25C. FUNERAL DIRECTOR ADDRESS 1639 N. BROADWAY			

Apr 1961

CVA

Hypertension

12

10

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10

10

## H-200 69 0682 CERTIFICATE OF DEATH

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MARY HICKS</b>		2. DATE AND HOUR OF DEATH <b>Jan 17, 1969 1PM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>14-03</b>		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVE.</b> <b>BALTO. MD. 21224</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>556 BAKER ST. 21217</b>					
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-27-83</b>	9. AGE (In years lost birthday) <b>85</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					
13. FATHER'S NAME <b>SILAS</b>		14. MOTHER'S MAIDEN NAME <b>JANE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-54-1725 T</b>		17. INFORMANT <b>BCH RECORDS: 4940 EASTERN AVE. 21224</b>	
18. <b>412.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>G.I. BLEEDING</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>H.A.S.G.V.D</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>		(If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? <b>(If in Baltimore City, give exact location)</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(did not)</del> attended the deceased from <b>Jan 2 1969</b> to <b>Jan 17 1969</b> , that (I) <del>(did not)</del> last saw the deceased alive on <b>Jan 17 1969</b> and that in (my) <del>(my)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(did not)</del> view the body after death.					
23A. SIGNATURE <b>Seymour Levine, MD</b>		23B. DATE SIGNED <b>Jan 17, 1969</b>			
23C. PHYSICIAN'S NAME (Type) <b>SEYMOUR LEVINE, M.D.</b>		23D. ADDRESS <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVE. 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-22-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>NEW CATHEDRAL</b>	
24D. LOCATION (City, town, or county) (State) <b>4300 OLD FAEDRICK RD BALTO, MD</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1969</b>		25B. NAME OF REGISTRAR <b>JOSEPH KNIGHT</b>		25C. FUNERAL DIRECTOR <b>1639 N. BROADWAY</b>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

WALL PAPER

OF BREEDING

H.A. 2. C.A.D.

for 15, 1941

for 15, 1941

X

Agnes, 1941

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">69 0683</span>
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">WRIGHT, GEORGIA</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">1/17/69 1139P.M.</span>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">BALTIMORE CITY</span>		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">33 THE JOHNS HOPKINS HOSPITAL</span>		C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span> D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
		E. STREET AND NUMBER <span style="font-size: 1.2em;">912 N. EDEN STREET</span>		
5. SEX <span style="font-size: 1.2em;">FEMALE</span>	6. RACE <span style="font-size: 1.2em;">NEGRO</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">10-16-12</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">56</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">None</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">ARK.</span>
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">GEORGE WALKER</span>		
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">CARRIE WARE</span>		15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		
16. SOCIAL SECURITY NO.		17. INFORMANT <span style="font-size: 1.2em;">MRS. LEWIS</span> ADDRESS <span style="font-size: 1.2em;">PASADENA MD</span>		
18. <span style="font-size: 1.2em;">5-30,91</span> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <span style="font-size: 1.2em;">Sudden bleeding into lungs.</span> <span style="font-size: 1.2em;">45 min</span>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Massive Exogenous Obesity -&gt; Pickwickian &gt; 10 yrs.</span>		
		(C) <span style="font-size: 1.2em;">on Respiator -&gt; T+E fistula.</span>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2/1</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">YES</span>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?		22. I certify that (1) this hospital attended the deceased from <span style="font-size: 1.2em;">12/16/69</span> to <span style="font-size: 1.2em;">1/17/69</span> 19 <span style="font-size: 1.2em;">69</span> and that (2) (we) last saw the deceased alive on <span style="font-size: 1.2em;">1/17/69</span> 19 <span style="font-size: 1.2em;">69</span> and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.		
23A. SIGNATURE <span style="font-size: 1.2em;">Edward D. Hank Jr.</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">1/17/69</span>		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Edward D. Hank Jr.</span>
23D. ADDRESS <span style="font-size: 1.2em;">1519 E. MONUMENT ST BALTIMORE, Md.</span>		24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">BURIAL</span>		
24B. DATE <span style="font-size: 1.2em;">1-21-69</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">MT CALVARY</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">A.A. COUNTY MD</span>
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JAN 21 1969</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">JOSEPH KNIG-AT 1639 N. BROADWAY</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">JOSEPH KNIG-AT 1639 N. BROADWAY</span>

Edward A. Hume  
Edward A. Hume



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 0684  
REG. NO.

BIRTH NO.

Batson

1. NAME OF DECEASED (Type or Print) <b>ALBERT COOK</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Johns Hopkins Hospital (DOA) 1-22-69</b>		3. DATE PRONOUNCED DEAD <b>January 19, 1969</b>		Month	Day	Year	Hour <b>12:36 A.M.</b>
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b>		B. COUNTY <b>8-06</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <b>male</b>	7. RACE <b>negro</b>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <b>1761 E. North Avenue</b>			
9. DATE OF BIRTH <b>3-9-51</b>		10. AGE (In years last birthday) <b>17</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EDDIE S. COOK</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		15. MOTHER'S MAIDEN NAME <b>LAMA BATSON</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>EDDIE S. COOK 1839 Rutland Ave.</b>		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Stab Wound of Chest</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>		22. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>		22B. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>1801 E. North Avenue</b>		22C. HOW DID INJURY OCCUR? <b>subj. stabbed during altercation</b>		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>1/19/69 12:30 A.M.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>subj. stabbed during altercation</b>		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23. ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>		23. DATE <b>1-23-69</b>		23. NAME OF CEMETERY or CREMATORY <b>BALTO NATIONAL</b>		23. LOCATION (City, town, or county) (State) <b>BALTIMORE Md</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-23-69</b>		24C. NAME OF REGISTRAR <b>Robert E. Jackson</b>		24D. FUNERAL DIRECTOR <b>JOSEPH KNIGHT 1639 N. Broadway</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1969</b>		24B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		24C. FUNERAL DIRECTOR <b>JOSEPH KNIGHT 1639 N. Broadway</b>		24D. ADDRESS <b>1639 N. Broadway</b>	

CERTIFICATE ANNEXED

10-2-21

Wd.

None

Wd

Wd.

Edie & Co. 1234 1234 1234  
1234 1234  
Edie & Co.

Wd.

VALLEY FOR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0685

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 0685

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Nash, Thelma Lee		1-19-69 9:35 a. m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital 1514 Division Street Baltimore, Maryland 21217				A. STATE Maryland B. COUNTY 13-02	
				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2122 Callow Avenue	
5. SEX Female	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-16-26	9. AGE (In years last birthday) 42	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Ga.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Alfred Smith			
14. MOTHER'S MAIDEN NAME Bessie Yancey		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. 218-26-8153		17. INFORMANT Paul Nash (husband) ADDRESS Same			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH RECURRENT CARCINOMA OF MID SIGMOID COLON 2 PERFORATION + ENDARY (A) IMMEDIATE CAUSE PERITONITIS DUE TO, OR AS A CONSEQUENCE OF: CARCINOMA MID SIGMOID COLON (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MOS. 1 YR.					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
21A. DATE OF OPERATION 1/12/69		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED OBSTRUCTION		21C. AUTOPSY? (Yes or No) YES	
21D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21E. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21F. HOW DID INJURY OCCUR?		21G. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21H. TIME OF INJURY (Month Day Year) (Approx.)		21I. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1-2-69 19 to 1-19-69 19 that (I) (we) last saw the deceased alive on 1-19-69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE D. C. WELCOMER, M.D. DEGREE				23B. DATE SIGNED 1-20-69	
23C. PHYSICIAN'S NAME (Type) D. C. WELCOMER, M.D. DEGREE				23D. ADDRESS 1106 HARLEM AVE 21217	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-23-69		24C. NAME OF CEMETERY OR CREMATORY Balto. Nat'l. Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. 1-19-69			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR 1735 Harford Ave. ABRES Marshall W. Jones, Jr.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 0686				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 0686					
1. NAME OF DECEASED (Type or Print) <b>Curtis, Morris</b>						2. DATE AND HOUR OF DEATH <b>1-16-69 10:15 a. M.</b>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>39 Provident Hospital 1514 Division Street Baltimore, Maryland</b>						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-03</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2141 W. North Avenue</b>							
5. SEX <b>Male</b>		6. RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-3-03</b>		9. AGE (In years last birthday) <b>65</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>?</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>William Curtis</b>						14. MOTHER'S MAIDEN NAME <b>Florence Bruscol</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Helen Scott (Sister)</b>				ADDRESS <b>813 N. Eden Street</b>			
18. <b>427.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Congestive Heart Failure</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At <input type="checkbox"/> At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <b>12-13-68</b> to <b>1-16-69</b> and that (I) (we) last saw the deceased alive on <b>1-16-69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.													
23A. SIGNATURE <b>G. TENGCO MD</b>						23B. DATE SIGNED <b>1-16-69</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			
23C. PHYSICIAN'S NAME (Type) <b>G. TENGCO MD</b>						23D. ADDRESS <b>Provident Hospital 1514 Division Street - Baltimore, Maryland</b>							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1/22/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary</b>		24D. LOCATION (City, town, or county) (State) <b>A. A. County, Md.</b>							
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1969</b>				25B. NAME OF REGISTRAR <b>James E. Lock</b>				25C. FUNERAL DIRECTOR <b>James E. Lock</b>				ADDRESS <b>1301 N. Chesa Ave</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 0687	
69 0687		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>August Prinzavalle</u>		2. DATE AND HOUR OF DEATH <u>1/17/69</u> <u>5:30 P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>3-02</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 Johns Hopkins Hospital</u>		C. CITY OR TOWN <u>Balt</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>904 Fawn St.</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. <del>MARRIED</del> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/4/94</u>	9. AGE (In years last birthday) <u>74</u>	If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PIPE LAYER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>ITALY</u>	
13. FATHER'S NAME <u>JOSEPH</u>		14. MOTHER'S MAIDEN NAME <u>MARY</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-05-3430</u>		17. INFORMANT <u>Mr. Anthony Prinzavalle</u>	
18. <u>5-99-01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>3 Pulmonary Embolus or CVA</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Gram Negative Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Urinary tract Infection</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 min.</u> <u>3 days</u> <u>5 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Wound infection, Debilitation, Arteriosclerosis</u>					
19A. DATE OF OPERATION <u>11/23/68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Intercostal @ colon</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11/23/68</u> 19 <u>68</u> to <u>1/17</u> 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>1/17</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Michael B. Marchildon, M.D.</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1/17/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>Michael B. Marchildon, M.D.</u>		23D. ADDRESS <u>J.H.H. Dept. Surgery</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>1/21/69</u>	24C. NAME OF CEMETERY or CREMATORY <u>Mount Olivet</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1969</u>		25B. NAME OF REGISTRAR <u>Frank Della Noce</u>		25C. FUNERAL DIRECTOR <u>322 S. High St.</u>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 0688		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 0688	
1. NAME OF DECEASED (Type or Print) GAETANO LAMBERTI			2. DATE AND HOUR OF DEATH 18 JAN 69 6 <sup>00</sup> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 MERCY HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 3-01 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 313 J. CENTRAL AVE.		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-12-97	9. AGE (In years last birthday) 72	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRICKLAYER		10B. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) ITALY	
13. FATHER'S NAME GEMARO LAMBERTI			14. MOTHER'S MAIDEN NAME CATHERINA <del>XXXXXXXXXX</del> VOTA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-12-9064		17. INFORMANT CARMEN LAMBERTI ADDRESS 313 J. CENTRAL AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II CHRONIC LUNG DISEASE (CHRONIC BRONCHITIS EMPHYSEMA) RIGHT LOWER LOBE PNEUMONIA			CAUSE OF DEATH (A) IMMEDIATE CAUSE MYOCARDIAL INFARCTION ACUTE DUE TO, OR AS A CONSEQUENCE OF: (B) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF: (C) DIABETES MELLITUS		
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 12:30 PM 18 Jan 19 69 to 6:00 PM 18 Jan 19 69 that (H) (we) last saw the deceased alive on 18 Jan 19 69 and that (H) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Salvatore R. DeLoehue M.D.			23B. DATE SIGNED 18 Jan 69		23C. PHYSICIAN'S NAME (Type) SALVATORE R. DELOEHUE M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 1/22/69		24C. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1969			25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Frank Doyle
25D. ADDRESS 342 S. H. RST.					

1880  
The following is a list of the  
names of the persons who  
were present at the  
meeting of the Board of Directors  
of the City of New York  
on the 1st day of January, 1880.

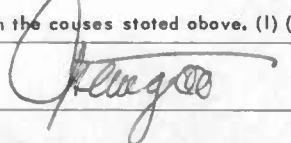
Wm. W. Smith, President  
John A. B. Smith, Secretary

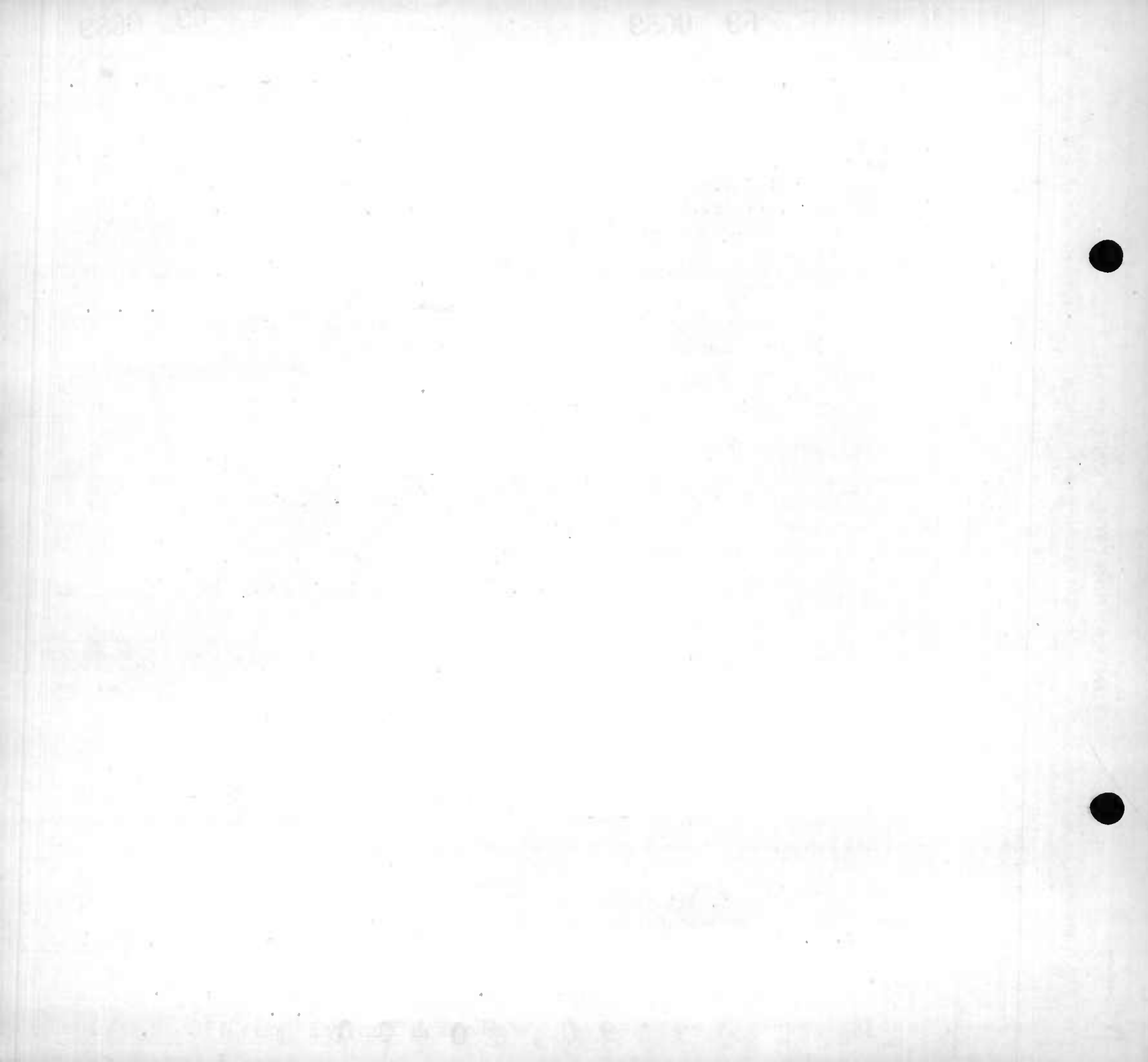
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 69 0689 CERTIFICATE OF DEATH

REG. NO. 69 0689

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Townes, Frank</b>		2. DATE AND HOUR OF DEATH <b>12:00 1-16-69 12:00 p. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>39 Provident Hospital 1514 Division Street Baltimore, Maryland</b>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-01</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1367 N. Stricker Street</b>		
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-31-95</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>?</b>	11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Albert Townes</b>			14. MOTHER'S MAIDEN NAME <b>Susie</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-10-7749</b>	17. INFORMANT <b>Mrs. Pearl Townes (Wife)</b>		ADDRESS <b>Same</b>
18. <b>4-10-9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> I <b>Large chronic Peptic Ulcer of Stomach</b> II <b>Rupture of artery and Massive Hemorrhage</b> <b>Acute &amp; Healed Myocardial Infarction</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>2</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1-16-69</b> 19 to <b>1-16-69</b> 19, that (I) (we) last saw the deceased alive on <b>1-16-69</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 			23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>Dr. G. Tengco</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/20/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1969</b>		25B. NAME OF REGISTRAR <b>2. Bailey</b>	
25C. FUNERAL DIRECTOR <b>V.R. Bailey</b>		25D. ADDRESS <b>Keoson Funeral Home 1348 N. Calhoun St</b>			



49-76-09 DD

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
K-450		69 0690		69 0690	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Ethel C. Kellum		17 Jan 69		1 29 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		MARYLAND		26-12	
BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
BALTIMORE, MARYLAND 21224		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER		F. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
4940 EASTERN AVENUE 21224		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5-11-89	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)	
				79	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
MARYLAND		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
NATHANIEL WEST		CORNELIA DOWNS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		216-05-4444D		4940 EASTERN AVENUE, 21224	
18. 43391		CAUSE OF DEATH		ADDRESS	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE		BALTIMORE CITY HOSPITALS RECORDS	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Cerebral thrombosis		2 yr.	
ANTECEDENT CAUSES		DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from		19 69 to		19 69	
that (1) (we) last saw the deceased alive on		Jan 16 19 69		and that in (my) (our) opinion death occurred on the date	
and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
David J. Riley MD		17 Jan 69			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
David J. Riley M.D.		B BALTIMORE CITY HOSPITALS 4940 Eastern Ave			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		1/20/69		Arbutus Mem. Pk.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 21 1969		Robert E. Johnson		V.R. Bailey	
				ADDRESS	
				NELSON FUNERAL HOME 1348 W. HANCOCK	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 0691
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Ella Brankham (Tilghman)		1-16-69 7:30 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital 1514 Division Street Baltimore, Maryland			A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1342 Stockton Street		
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ? DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 8, 1899	9. AGE (In years last birthday) 69	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) D. S. S.		10B. KIND OF BUSINESS OR INDUSTRY ?	11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?	17. INFORMANT Edward Mack (son)		ADDRESS 1734 Poplar Grove St.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Pneumonia, basal, bilateral, heart failure			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) no			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 1-16-69 19 to 1-16-69 19, that (I) (we) last saw the deceased alive on 1-16-69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]			23B. DATE SIGNED 1-16-69		23C. PHYSICIAN'S NAME (Type) Dr. G. Tengao
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 1/20/69		
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.			24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
25A. DATE RECEIVED BY HEALTH DEPT. JAN 21 1969			25B. NAME OF REGISTRAR [Signature]		
25C. FUNERAL DIRECTOR V.R. Bailey			ADDRESS Kelson Funeral Home 1348 N. Calhoun St		

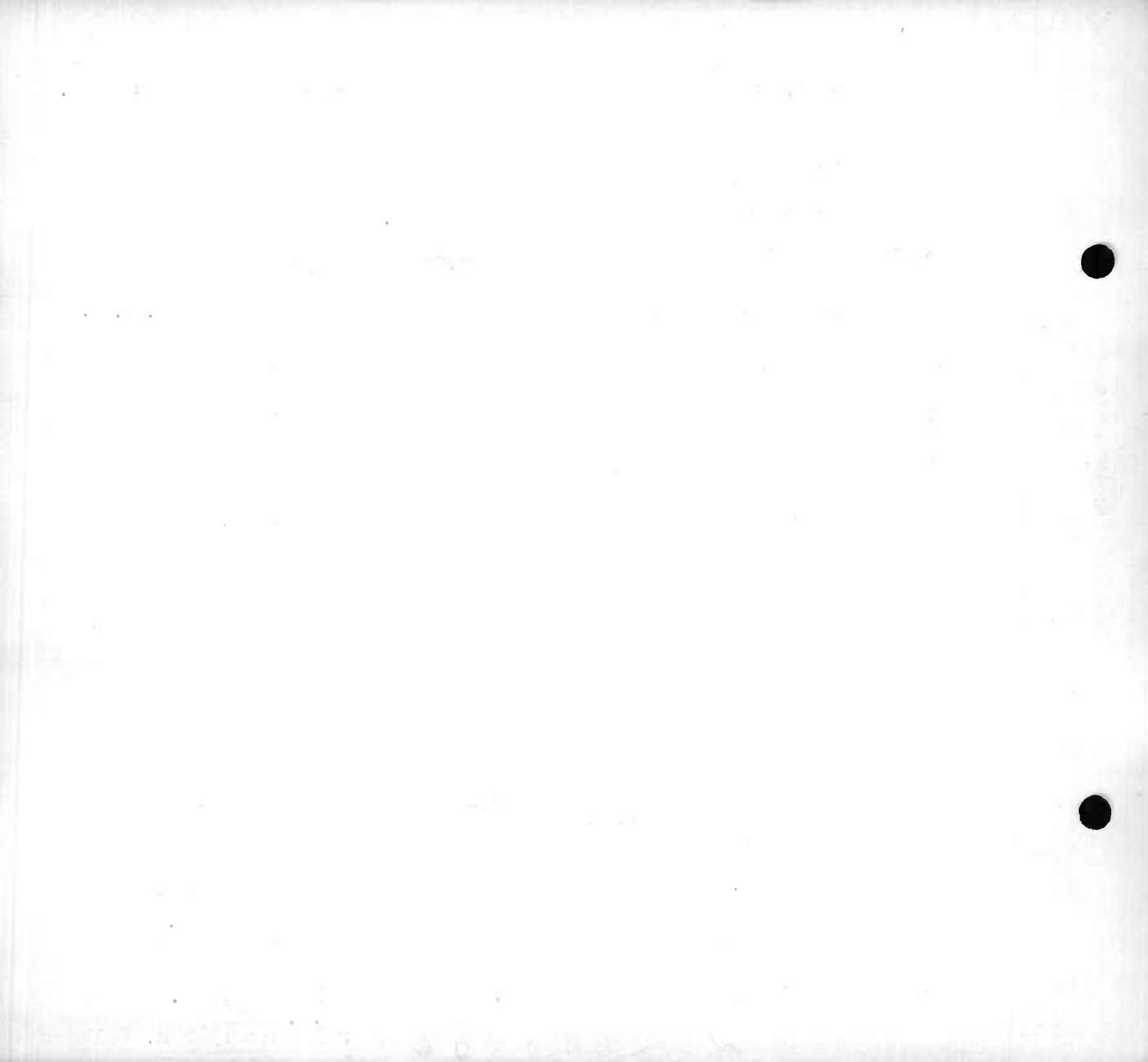




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>69 0692</b>
BIRTH NO. <b>69 0692</b>		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <b>Dorsey, Sadie</b>		2. DATE AND HOUR OF DEATH <b>1-19-69 5:35 a. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE [Where deceased lived. If institution; residence before admission] A. STATE <b>Maryland</b> B. COUNTY <b>16-02</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>39 Provident Hospital</b> <b>1514 Division Street</b> <b>Baltimore, Maryland</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>Female</b>		6. RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>Aug. 14, 1898</b>		9. AGE (In years last birthday) <b>70</b>		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>?</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Charles Fisher</b>		
14. MOTHER'S MAIDEN NAME <b>Georgianna Washi ngton</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] <b>No</b>		
16. SOCIAL SECURITY NO. <b>215-01-7992</b>		17. INFORMANT <b>Lillian Johnson (neice)</b> ADDRESS <b>928 Whitelock Street</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <b>No</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from <b>1-18-69</b> to <b>1-19-69</b> and that (I) (we) last saw the deceased alive on <b>1-19-69</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE <b>Ahsan S. Khan</b> 23B. DATE SIGNED <b>1-19-69</b> 23C. PHYSICIAN'S NAME (Type) <b>AHSAN S. KHAN MD</b> 23D. ADDRESS <b>Provident Hospital Inc.</b> <b>1514 Division Street - Baltimore, Maryland</b> 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b> 24B. DATE <b>1/23/69</b> 24C. NAME OF CEMETERY OR CREMATORY <b>Mt Auburn Cem.</b> 24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b> 25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1969</b> 25B. NAME OF REGISTRAR <b>Kelso Funeral Home</b> 25C. FUNERAL DIRECTOR <b>V.R. Bailey</b> ADDRESS <b>1348 N. Calhoun st</b>				



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0693

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

69 0693

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Hightower, Charles</b>		2. DATE AND HOUR OF DEATH <b>1-20-69</b> <b>5:30 a.</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>13-01</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>39 Provident Hospital</b> <b>1514 Division Street</b> <b>Baltimore, Maryland 21217</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>2422 Linden Avenue</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ? DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-31-29</b>	9. AGE (In years last birthday) <b>39</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Joseph J. Hock</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>230-34-6201</b>		17. INFORMANT <b>Inez Hamilton (Friend)</b> ADDRESS same	
18. <b>4/12/21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE <b>Uremia</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Hypertensive Cardiovascular Disease &amp; Nephrosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>2 yrs.</b>	
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-30-68</b> 19__ to <b>1-20-69</b> 19__ that (I) (we) last saw the deceased alive on <b>1-20-69</b> 19__ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Elijah Saunders</b>		23B. DATE SIGNED <b>1-20-69</b>			
23C. PHYSICIAN'S NAME (Type) <b>ELIJAH SAUNDERS</b>		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1/23/69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Vermont Hill</b>	
		24D. LOCATION (City, town, or county) (State) <b>Halifax Va.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Charles Johnson</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 0694

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)NICHOLAS MAGOROKOS  
(MAGARAKOS)2. DATE  
OF  
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

00 1412 W. Lombard Street

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

January 9, 1969

9:05 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

19-02

6. SEX

Male

7. RACE

White

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ ?DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

2-17-1891

10. AGE (In years  
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1412 W. Lombard Street

11. BIRTHPLACE (State or foreign country)

2

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

2

14B. KIND OF BUSINESS OR INDUSTRY

2

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

yes

# One

17. SOCIAL  
SECURITY NO.

218-54-0045

18. INFORMANT

Mrs. Ruth Schuler 1412 W Lombard St

ADDRESS

19. 412.4 I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

January 9, 1969

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

Jan 17 1969

24C. NAME of CEMETERY or CREMATORY

Baltimore National Cem

24D. LOCATION (City, town, or county)

Baltimore, Md

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 21 1969

25B. NAME OF REGISTRAR

Bob E. Fisher, Jr.

25C. FUNERAL DIRECTOR

Thomas J. Kerry, Inc 1600 Hollins St

ADDRESS

VALLEY

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

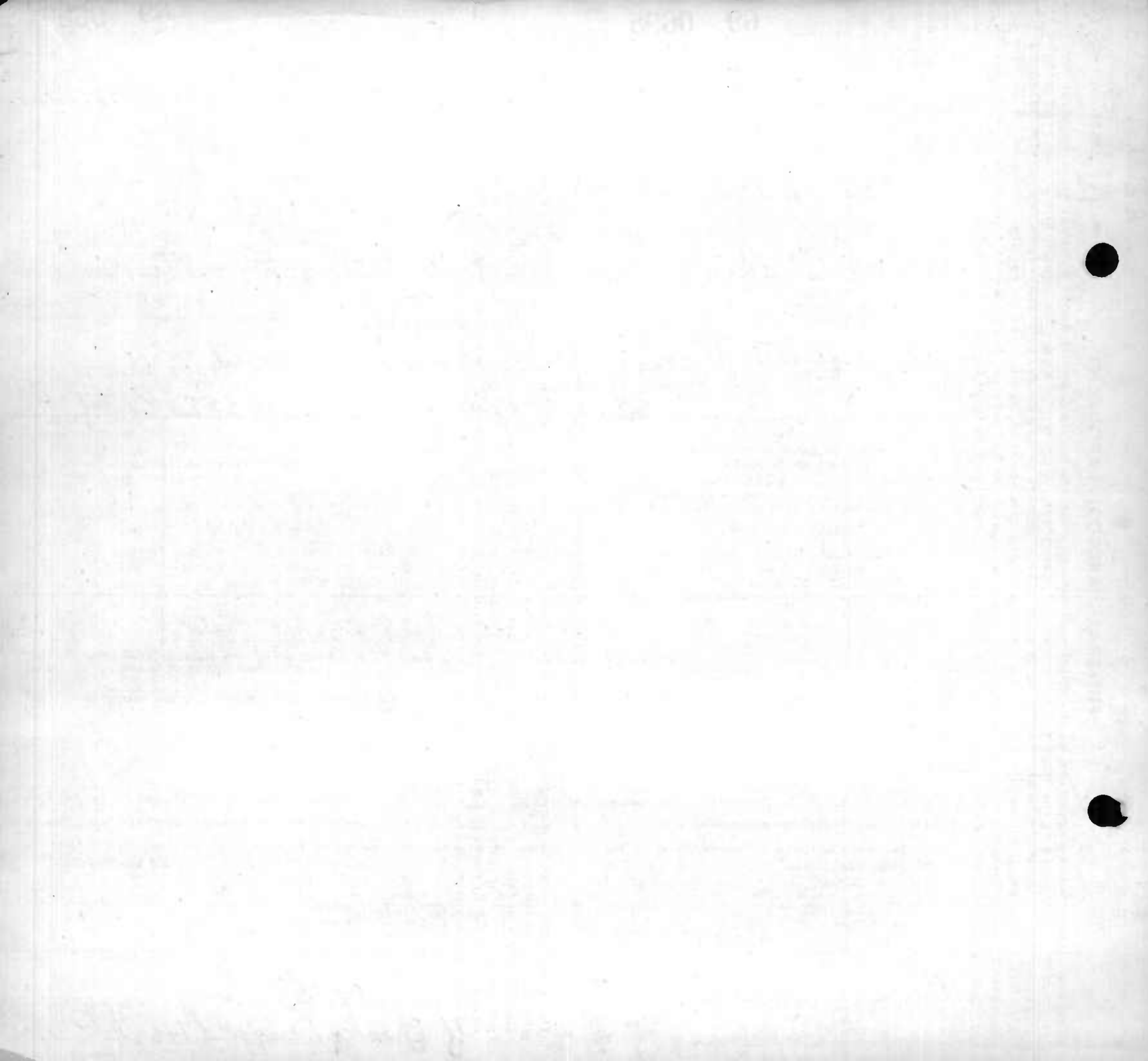
69 0695

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

69 0695

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>George S. Marshall</i>		2. DATE AND HOUR OF DEATH <i>Jan 18 - 1969 10 P.M.</i>	
3. PLACE IN BALTIMORE MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>16-03</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>00828 N. Mount St</i>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Male</i>		6. RACE <i>Colored</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>Jan 18 - 1969</i>		9. AGE (In years last birthday) <i>85</i>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waiter</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Singleton Marshall</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Copeland</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <i>Yes, give war or dates of service</i>		16. SOCIAL SECURITY NO. <i>206-10-2926</i>		17. INFORMANT <i>George Marshall</i> ADDRESS <i>1323 Eutan-Plu</i>	
18. <i>440.91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>ARTERIOSCLEROSIS (GEN.)</i> (B) <i>SENILITY</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>TERMINAL CARDIAC + RENAL FAILURE</i>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1/7/69</i> to <i>1/18/69</i> that (I) (we) last saw the deceased alive on <i>1/18/69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>G. L. Banfield</i>		23B. DATE SIGNED <i>1/20/69</i>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <i>G. L. BANFIELD M.D.</i>		23D. ADDRESS <i>722 N. Fulton AVE BALT.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Jan 22/69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt Auburn</i>	
24D. LOCATION <i>Balto City</i>		(City, town, or county) (State) <i>Md</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 21 1969</i>		25B. NAME OF REGISTRAR <i>Reg. 52. J. B. ...</i>		25C. FUNERAL DIRECTOR <i>J. B. ...</i> ADDRESS <i>14637. Cony St</i>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
69 0696		69 0696		69 0696	
BIRTH NO. <i>Italy</i>		1. NAME OF DECEASED (Type or Print) <b>Charles Darrell Trout, Jr.</b>		2. DATE AND HOUR OF DEATH <b>Jan. 16, 1969</b> <b>12:45 PM</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>US Public Health Service Hospital 3100 Wyman Parkway</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <i>Howard</i> <b>63-00</b> C. CITY OR TOWN <b>Elkridge</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>Rt. 4 Box 66</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/16/64</b>	9. AGE (In years last birthday) <b>5</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Italy</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Charles D. Trout, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Guinola Fyffe</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT ADDRESS <b>Records- US PHS Hospital, Balto, Md.</b>	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Bronchopneumonia</b>  (B) <b>Rhabdomyosarcoma, orbit</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  <b>Days</b>  <b>18 mos.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Jan. 16</b> 19 <b>69</b> to <b>Jan. 16</b> 19 <b>69</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Jan. 16</b> 19 <b>69</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (d/d not) view the body after death.					
23A. SIGNATURE <i>Walter F. Oster</i>		23B. DATE SIGNED <b>1/16/69</b>		23C. PHYSICIAN'S NAME (Type) <b>Walter F. Oster, Surgeon (R)</b>	
23D. ADDRESS <b>US PHS Hospital, Balto, Md.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>JAN 21 1969</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Wheelerburg</b>		24D. LOCATION (City, town, or county) (State) <b>Wheelerburg, Ohio</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>James M. Fields</i>		25C. FUNERAL DIRECTOR ADDRESS <b>Balto, Md.</b>	

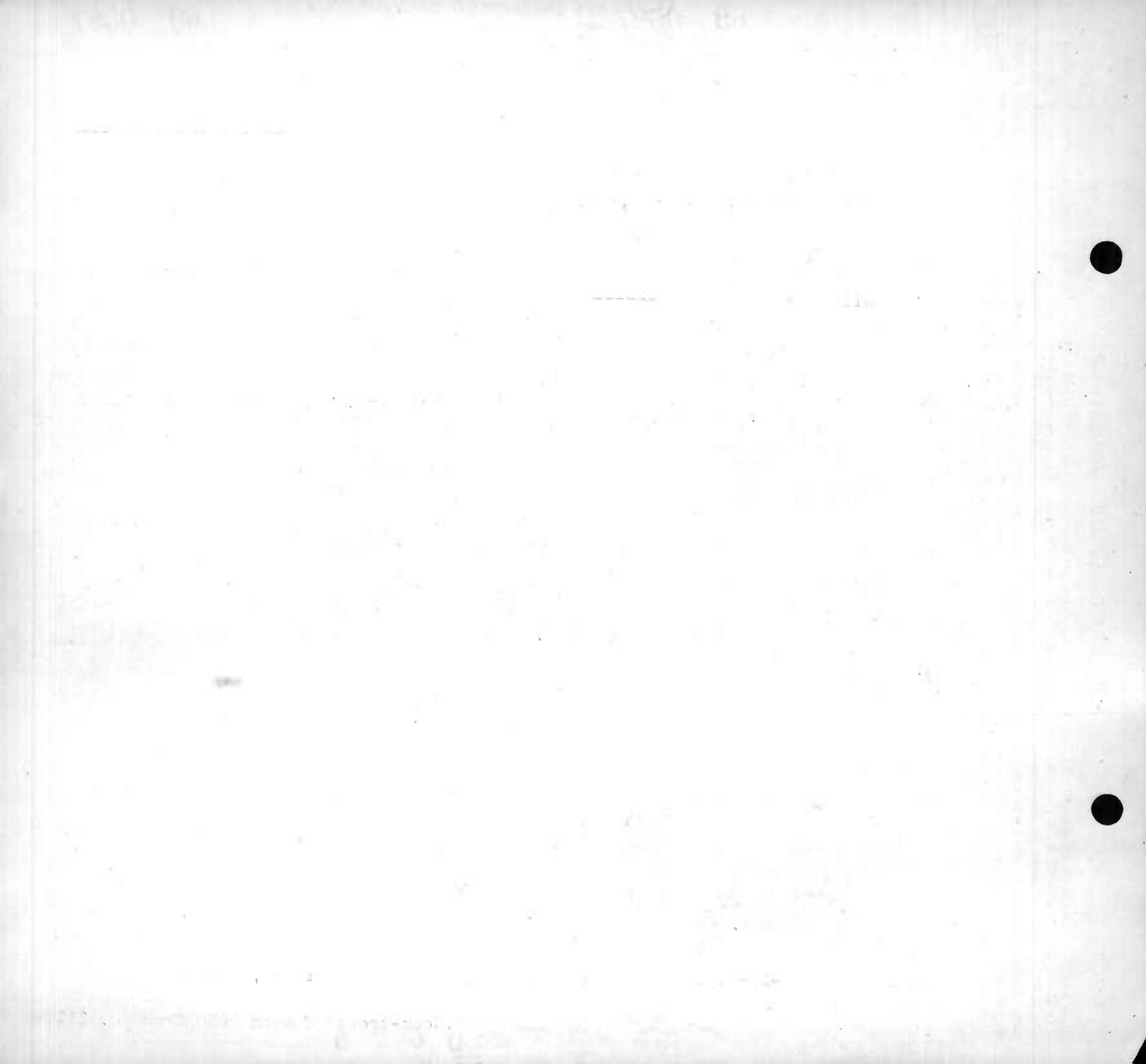


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0697 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH** REG. NO. 69 0697

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>VIOLA GEIGER</b>		2. DATE AND HOUR OF DEATH <b>1/18/69 1:40 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>3/ BALTIMORE CITY HOSPITALS</b> <b>4940 Eastern Avenue, Baltimore, Maryland 21224</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER <b>2146 VAILTOWN ROAD 21220</b>					
5. SEX <b>FEMALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-15-18</b>	9. AGE (In years lost birthday) <b>50</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					
13. FATHER'S NAME <b>Frank Simpson</b>			14. MOTHER'S MAIDEN NAME <b>Madison Walker</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. ?		17. INFORMANT <b>Records: BCH-4940 Eastern Avenue 21224</b>	
18. <b>250.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>TENSION PNEUMOTHORAX</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>STAPHYLOCOCCAL PNEUMONIA</b>			DUE TO, OR AS A CONSEQUENCE OF: <b>at least 10 days</b>		
<b>DIABETES MELLITES -</b>			<b>3 yrs.</b>		
<b>PT. ON ART RESPIRATOR</b>			<b>2 HR.</b>		
<b>PT IS DEAF AND NEARLY MUTE</b>			<b>5 yrs.</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>1/17/69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>LUNG ABCESS &amp; CAVITY</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (the) (this hospital) attended the deceased from <b>1/5/69</b> to <b>1/18/69</b> and that (the) (we) last saw the deceased alive on <b>1/18/69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>John E. Yount M.D.</b>				23B. DATE SIGNED <b>1/18/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOHN E. YOUNT M.D.</b>				23D. ADDRESS <b>4940 EASTERN AVENUE BALTIMORE MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-21-1969</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Wm. Cook-Brooks</b>		25C. FUNERAL DIRECTOR <b>Towson 1050 York Rd. 21204</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0698 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH REG. NO. 69 0698

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ZOLA B. JERNIGAN</b>		2. DATE AND HOUR OF DEATH <b>1-17-69 11<sup>00</sup> P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>PA</b> B. COUNTY <b>V-35</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>USPAS HOSPITAL 2X BALTIMORE, MD.</b>			C. CITY OR TOWN <b>LEWISBURG</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>631 McCLAY AVE.</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-19-95</b>	9. AGE (In years last birthday) <b>72</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>WILLIAM M. HARRELL</b>			14. MOTHER'S MAIDEN NAME <b>LOCRETIA WILLIAMSON</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>?</b>		16. SOCIAL SECURITY NO. <b>718-12-2158</b>		17. INFORMANT ADDRESS <b>USPAS HOSPITAL RECORD</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>203101</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pulmonary edema + hemoptysis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hours</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>			(B) DUE TO, OR AS A CONSEQUENCE OF: <b>acute myelogenous leukemia</b>		<b>days</b>
			(C) .....		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>none</b>					
19A. DATE OF OPERATION <b>2 none</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20A. AUTOPSY? (Yes or No) <b>yes</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>no</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>—</b>	
21D. TIME OF INJURY (Approx.) <b>—</b>		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>—</b>	
22. I certify that <del>(X)</del> (this hospital) attended the deceased from <b>12-17</b> 19 <b>68</b> to <b>1-17-69</b> 19 <b>69</b> , that <del>(X)</del> (we) last saw the deceased alive on <b>1-17-</b> 19 <b>69</b> and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(X)</del> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>James M Weaver</b>				23B. DATE SIGNED <b>1-18-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>JAMES M WEAVER MD.</b>				23D. ADDRESS <b>—</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-21-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Olive Branch Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Portsmouth, Virginia</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Everly-Wheatley Funeral Home, Alex. Va.</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0699

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

69 0699

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

ROBERT MEAKIN PERRY

2. DATE AND HOUR OF DEATH

JAN 18-1969

4 A.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

49 NORTH Charles Gen Hosp.  
2724 N. CHARLES ST.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

CARNEY

BALTIMORE

C. CITY OR TOWN

Carney

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

3016 Fifth AVE.

21234

5. SEX

M

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

4-22-05

9. AGE (In years last birthday)

63

If Under 1 Yr. Months

Days

If Under 24 Hrs. Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

RET. POLICEMAN

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

J. McFEELEY PERRY

14. MOTHER'S MAIDEN NAME

GRACE MEAKIN?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

YES

Peace Time

16. SOCIAL SECURITY NO.

212-36-8370

17. INFORMANT

HOSPITAL CHART

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A), stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

acute pulmonary embolus

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

acute meningitis

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from 1/10 1969 to 1/18 1969. that (I) last saw the deceased alive on 1/18/69 19 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (yes) (did) (did not) view the body after death.

23A. SIGNATURE

Edward Sherer

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type)

Ed Sherer

DEGREE

23D. ADDRESS

N. Char. Gen.

24A. BURIAL CREMATION REMOVAL (Specify)

Burial

24B. DATE

1/22/69

24C. NAME of CEMETERY or CREMATORY

Balto. National Cem.

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 21 1969

25B. NAME OF REGISTRAR

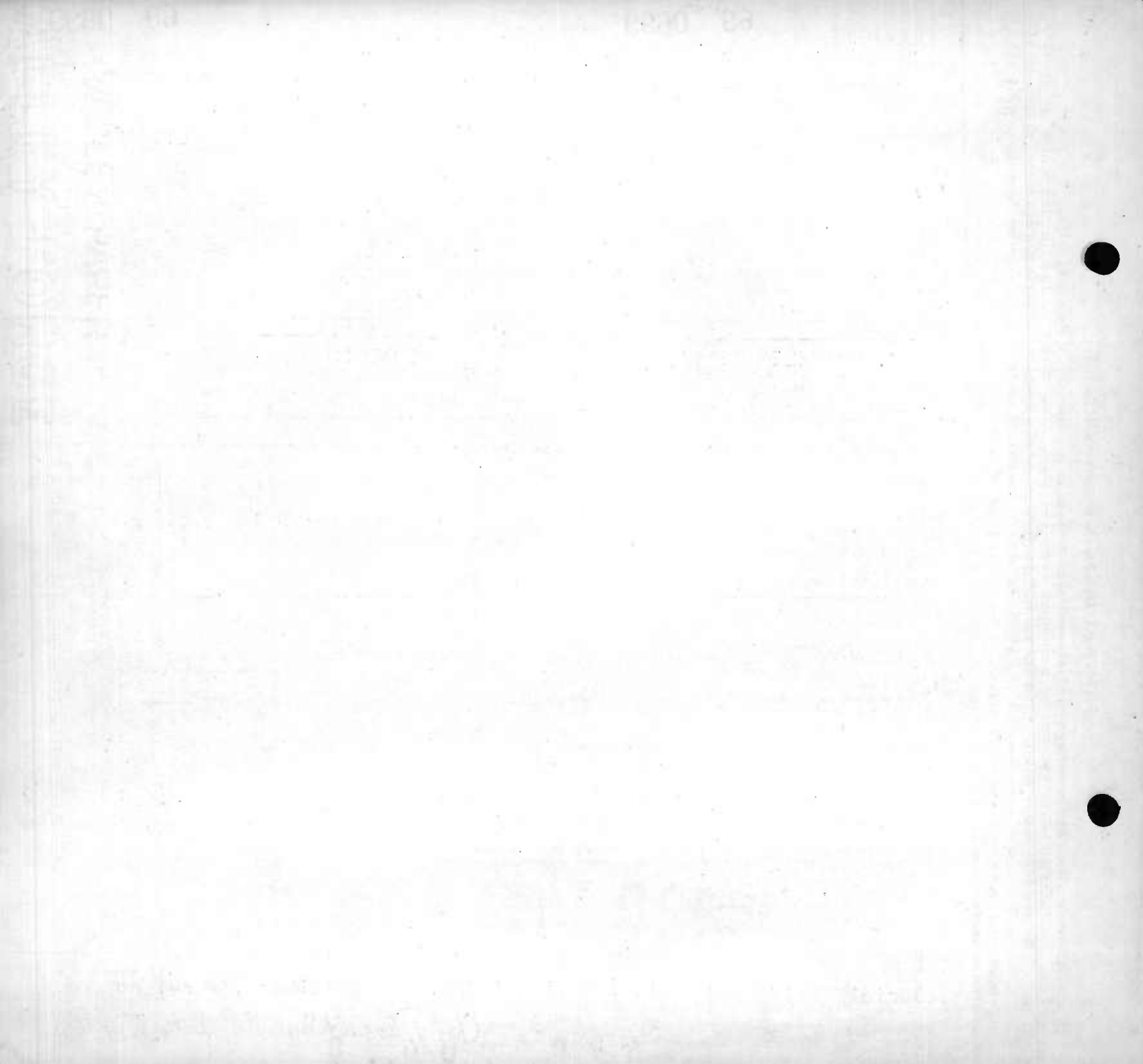
John E. Farber

25C. FUNERAL DIRECTOR

Chas T. Evans & Son

ADDRESS

8802 HARTFORD RD





# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>ARTHUR GILLASPEY</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>January 17, 1969 12:37 AM</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3702 Sequoia Avenue</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 17, 1969 12:37 A.M.</b>	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> <b>15-11</b>					
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>5-16-1913</b>		10. AGE (In years lost birthday) <b>55</b> <del>56</del>		E. STREET AND NUMBER <b>3702 Sequoia Avenue</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>P. Hammond Gillaspey</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seaman</b>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>Lillian Tyrrell</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		17. SOCIAL SECURITY NO. <b>216-09-3459</b>		18. INFORMANT ADDRESS <b>M. Elaine Ward-6509 S. Charter Road</b>	
19. <b>5-7-18</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Fatty metamorphosis of liver</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			21. AUTOPSY? (Yes or No) <b>yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>1/17/69</b>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-20-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Parkwood Cemetery</b>	
		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Marion Armacost-4600 Liberty Hghts. Ave</b>	

1. The first part of the report is a summary of the work done during the year.

2. The second part is a detailed account of the work done during the year.

3. The third part is a summary of the work done during the year.

4. The fourth part is a summary of the work done during the year.

5. The fifth part is a summary of the work done during the year.

6. The sixth part is a summary of the work done during the year.

7. The seventh part is a summary of the work done during the year.

8. The eighth part is a summary of the work done during the year.

9. The ninth part is a summary of the work done during the year.

10. The tenth part is a summary of the work done during the year.

11. The eleventh part is a summary of the work done during the year.

12. The twelfth part is a summary of the work done during the year.

13. The thirteenth part is a summary of the work done during the year.

14. The fourteenth part is a summary of the work done during the year.

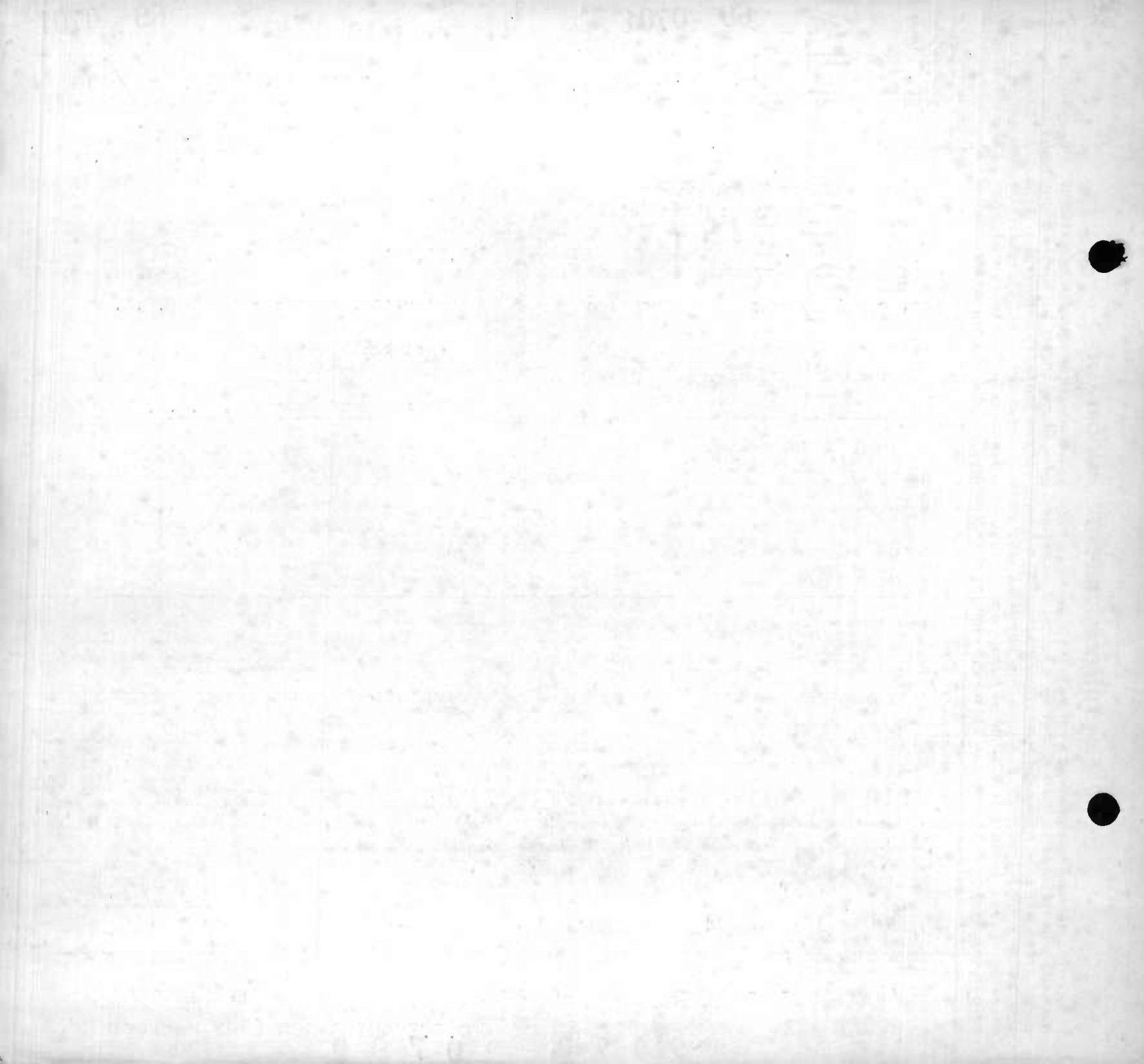
15. The fifteenth part is a summary of the work done during the year.

VALLEY POLICE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
69 0701		CERTIFICATE OF DEATH		69 0701	
1. NAME OF DECEASED (Type or Print) <b>James Joseph Savage (BRO. HENRY CFX)</b>		2. DATE AND HOUR OF DEATH <b>January 18, 1969 8:30 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>94 Mount St. Joseph College 4403 Frederick Avenue Baltimore, Maryland 21229</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> 8. COUNTY <b>25-41</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>4403 Frederick Avenue</b>			
5. SEX <b>M</b>	6. RACE <b>Cau.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 25, 1913</b>	9. AGE (In years last birthday) <b>55</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sec. School Teacher</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Education</b>		11. BIRTHPLACE (State or foreign country) <b>Louisville, Kentucky</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Patrick Savage</b>		14. MOTHER'S MAIDEN NAME <b>Henrietta Holtman</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Brother Howard McCarthy, C.F.X.</b>	
18. <b>410. C</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction 8:30 pm</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) Hypertensive Cardio. Disease</b> <b>(C) Arteriosclerosis</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1966</b> to <b>1968</b> , that (I) (we) lost saw the deceased alive on <b>app. Oct. 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Alfredo Aldave M.D.</b>		23B. DATE SIGNED <b>1-19-69</b>		23C. PHYSICIAN'S NAME (Type) <b>Alfredo Aldave M.D.</b>	
23D. ADDRESS <b>6411 Frederick Rd. Baltimore Md. 21228.</b>		23E. PHYSICIAN'S DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-22-69</b>		24C. NAME of CEMETERY or CREMATORY <b>Calvary Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Louisville, Kentucky</b>		24E. STATE (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1969</b>		25B. NAME OF REGISTRAR <b>0758. Indiana</b>		25C. FUNERAL DIRECTOR ADDRESS <b>C.F. EVANS &amp; SON 8802 Harford Rd.</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <span style="float: right;">69 0702</span>	
1. NAME OF DECEASED (Type or Print) <b>FRIEDA C. BRANDT</b>			2. DATE AND HOUR OF DEATH <b>Jan. 18, 1969</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md. 21224</b> B. COUNTY <b>6-02</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33 99 Johns Hopkins Hosp. (DOA)</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>119 N. Glover St.</b>		
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/15/11</b>	9. AGE (In years last birthday) <b>57</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <b>Schneider</b>			14. MOTHER'S MAIDEN NAME <b>unknown</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
			17. INFORMANT <b>4904 Crenshaw Ave. ADDRESS 21206</b> <b>Ronald W. Brandt, son,</b>		
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute coronary</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>Arteriosclerotic heart disease</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Aug 1960</b> to <b>JAN 18 1969</b> , that (I) (we) lost the deceased on <b>JAN 10 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dr. Andrew Lemischka</b>			23B. DATE SIGNED <b>1/20/69</b>		
23C. PHYSICIAN'S NAME (Type) <b>Dr. Andrew Lemischka</b>			23D. ADDRESS <b>2608 E. Baltimore St.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/21/69</b>		24C. NAME of CEMETERY or CREMATORY <b>Gardens of Faith</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>	
				ADDRESS <b>2601 E. Madison St.</b>	

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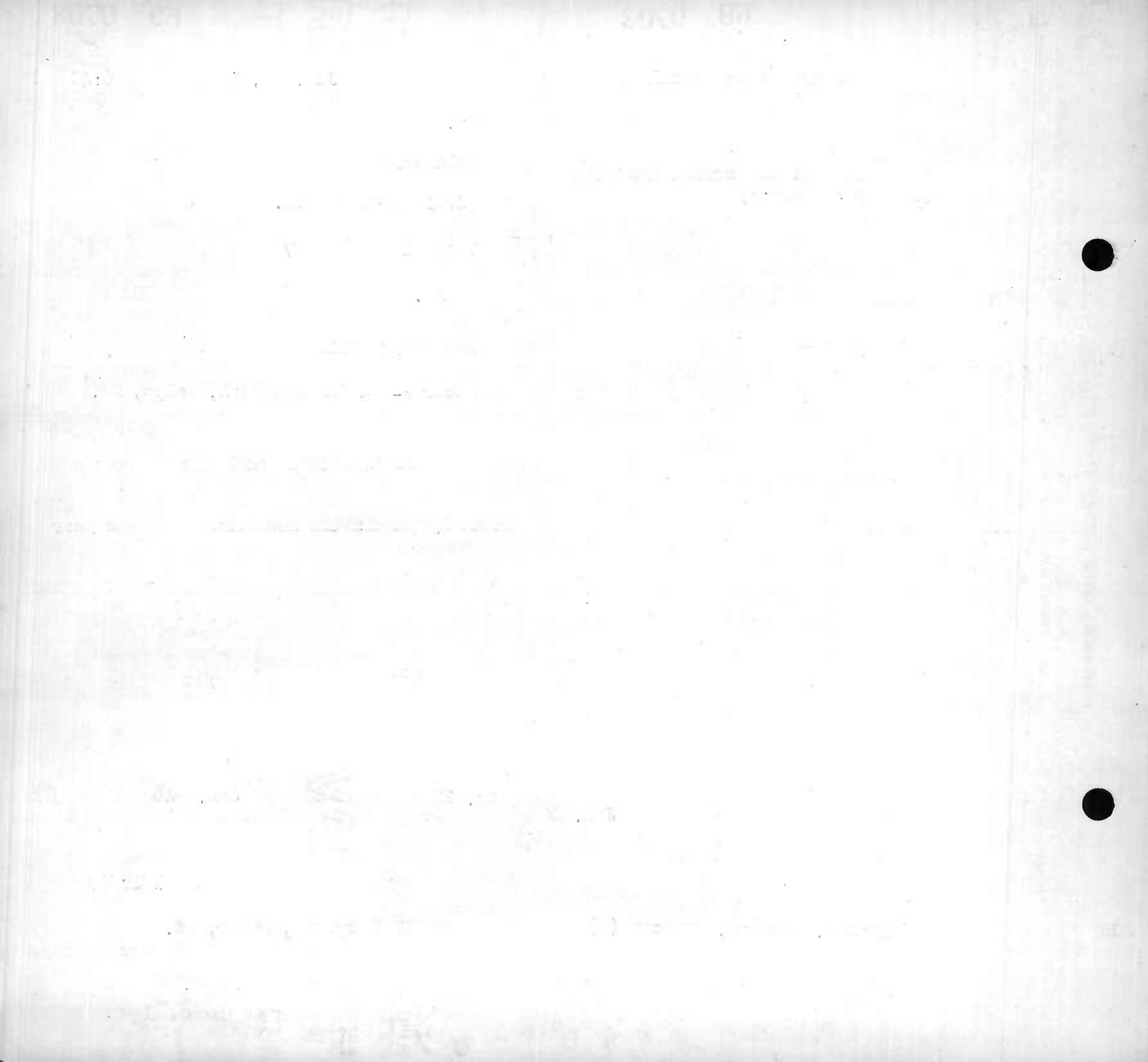
1874

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">69 0703</span>	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Teresa Marie Powell</b>		2. DATE AND HOUR OF DEATH <b>Jan. 16, 1969 6:40 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>US Public Health Service Hospital 3100 Wyman Parkway</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>21206</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>4503 Shamrock Ave.</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/30/61</b>	9. AGE (In years last birthday) <b>7</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
13. FATHER'S NAME <b>Donald Powell</b>			14. MOTHER'S MAIDEN NAME <b>Catherine Wills</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Records- US PHS Hospital, Balto, Md.</b>	
18. <b>204.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Severe bilateral pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) <b>Acute lymphoblastic leukemia</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b>  <b>One year</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Dec. 22, 1968</b> to <b>Jan. 16, 1969</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Jan. 16, 1969</b> and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death.					
23A. SIGNATURE <i>N. H. Peckham</i> DEGREE				23B. DATE SIGNED <b>1/17/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Norman H. Peckham, Surgeon (R)</b> DEGREE				23D. ADDRESS <b>US PHS Hospital, Balto, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/21/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1969</b>		25B. NAME OF REGISTRAR <i>Regina E. Johnson</i>		25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc. 3331 Brehms Lane</b>	



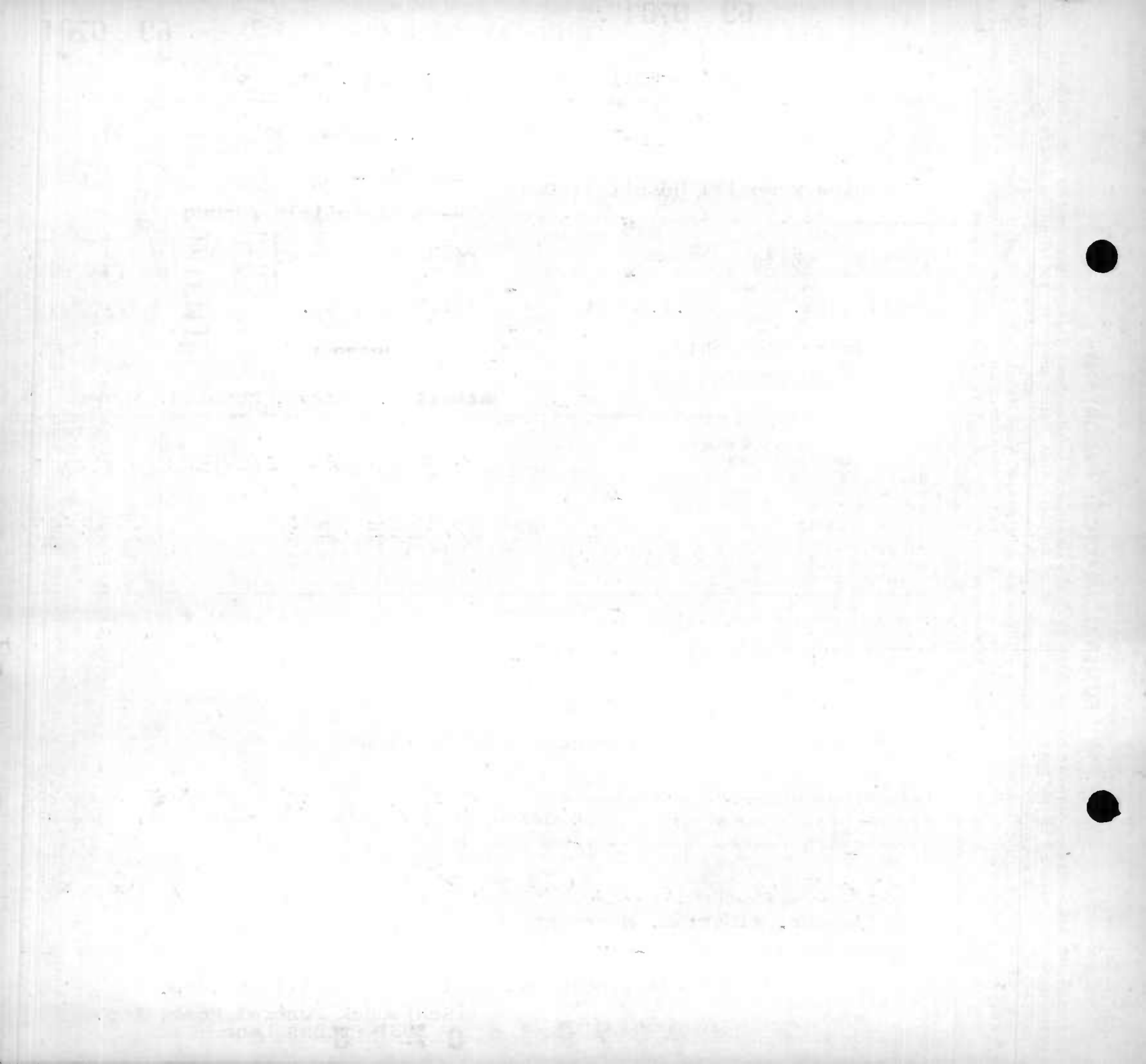




**FUNERAL DIRECTOR: IMPORTANT**

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>69 0704</b>
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH
		<b>ELVA HELEN TERRYS</b>		<b>Jan. 15, 1969</b>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital (DOA)</b>		A. STATE <b>Md.</b> B. COUNTY <b>26-41</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER <b>5518 Plainfield Avenue</b>		
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/10/26</b>	9. AGE (In years last birthday) <b>42</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Credit Dept.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>W.T. Grant</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>
13. FATHER'S NAME <b>Harry Albrecht</b>		14. MOTHER'S MAIDEN NAME <b>Helen Vain</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Algert V. Terrys, husband, above</b>	
18. <b>471X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>PNEUMONIA, BILATERAL</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) <b>INFLUENZA</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b>  <b>2 WEEKS</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>1/3</b> 19 <b>69</b> to <b>1/15</b> 19 <b>69</b> , that (I) (we) lost saw the deceased alive on <b>1/11</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Albert C. Herrmann, M.D.</b>		23B. DATE SIGNED <b>1/16/69.</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. Albert C. Herrmann</b>
23D. ADDRESS <b>5525 Belair Road</b>		23E. DEGREE		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1/20/69</b>	24C. NAME of CEMETERY or CREMATORY <b>Baltimore National Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
25A. DATE REC'D. BY HEALTH DEPT. <b>JAN 21 1969</b>		25B. NAME OF REGISTRAR <b>Albion E. Johnson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc. 3831 Brehms Lane</b>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
69 0705 CERTIFICATE OF DEATH

REG. NO. 69 0705

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ROBERT THOMPSON</b>		2. DATE AND HOUR OF DEATH <b>1-16-1969 10 35 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>THE UNION MEMORIAL HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>21213</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3101 PELHAM AVE</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-28-92</b>	9. AGE (In years last birthday) <b>76</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman-Brick Constr.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Frank Miller Co.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND Baltimore</b>	
13. FATHER'S NAME <b>William D. Thompson</b>			14. MOTHER'S MAIDEN NAME <b>Maggie Schmidt</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-05-9794</b>		17. INFORMANT <b>Wm. C. Thompson, son, THE CHART</b> ADDRESS <b>8410 Loch Raven 21204</b>	
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary tuberculosis.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Massive aspiration</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			<b>Y.S.</b>		
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1-7-69</b> to <b>1-16-69</b> , that (I) (we) last saw the deceased alive on <b>1-16-69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Chon Kee Ryu MD</b>			23B. DATE SIGNED <b>JAN. 16 1969</b>		23C. PHYSICIAN'S NAME (Type) <b>CHON KEE RYU MD</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>1/20/69</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cem.</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1969</b>		
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>			25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b> ADDRESS <b>3331 Brehms Lane</b>		

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 0706				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 69 0706	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>Anna Henkelmann</b>		2. DATE AND HOUR OF DEATH <b>1-17-69 11:55 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b>		(If not in hospital or institution, give street address or location) <b>3034 Fleetwood Avenue</b>		A. STATE <b>Md.</b>		B. COUNTY <b>27-45</b>	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore,</b>				D. STREET ADDRESS (If rural, give location) <b>3034 Fleetwood Avenue</b>			
5. SEX <b>Female</b>	6. RACE <b>Cau.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>12-31-1904</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Gustav Wenzelwiski</b>				14. MOTHER'S MAIDEN NAME <b>Rosalie Truschinski</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-12-3857</b>		17. INFORMANT ADDRESS <b>Henry Henkelmann Jr. 1434 Walker Avenue 21212</b>			
18. <b>1978 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Cancer of liver</b> DUE TO (A) <b>Cancer of liver</b> (B) <b>18 mos</b> (C) <b>18 mos</b>				CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH			
19. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1953 to Jan 17, 1969</b> , that (I) <del>was</del> lost saw the deceased alive on <b>Jan 15, 1969</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>do</del> (did) <del>not</del> view the body after death.							
23A. SIGNATURE <b>Ronald Jandorf</b> M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>1-17-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>R Donald Jandorf</b> M.D.				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-20-1969</b>		24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Co. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fabry</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Lassahn Funeral Home 7401 Belair Road</b>			

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 0707	
BIRTH NO.		T-640 69 0707		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type, Jr. or Part)		2. DATE AND HOUR OF DEATH		M.	
Veronica I Terrell		JAN 13 1969 12 NOON			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		53-00	
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		A. STATE MARYLAND		B. COUNTY BALTIMORE	
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
8. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME NICK KLUMP	
14. MOTHER'S MAIDEN NAME ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215 16 7038D	
17. INFORMANT BALTIMORE CITY HOSPITALS INFORMATION		18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) Heart failure C.V.A. + diabetes DUE TO, OR AS A CONSEQUENCE OF: (C) Generalized arteriosclerosis			
19. DATE OF OPERATION 2		20. AUTOPSY? (Yes or No) YES		21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
22. I certify that (I) (attending physician) attended the deceased from 1/13 19 69 to 1/17 19 69, that (I) ( ) last saw the deceased alive on 1/17 19 69 and that in (my) ( ) opinion death occurred on the date and hour and from the causes stated above. (I) ( ) (did) ( ) view the body after death.		23. SIGNATURE Seymour Levine		23B. DATE SIGNED Jan 17, 1969	
23A. PHYSICIAN'S NAME (Type) SEYMOUR LEVINE M.D.		23C. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE MD. 21224		23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE MD. 21224	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 1/21/69		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. JAN 21 1969		24F. NAME OF REGISTRAR Robert E. Terrell	
24G. NAME OF REGISTRAR Robert E. Terrell		24H. ADDRESS Bruzdzinski Funeral Home 1407 Eastern Ave.		24I. ADDRESS Bruzdzinski Funeral Home 1407 Eastern Ave.	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0708 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO.

69 0708

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MARY E. MANTOLL</b>		2. DATE AND HOUR OF DEATH <b>11/19/69 3:15 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>25-72</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>38 University Hospital</b> <b>Greene Street, Balto., Md.</b>			C. CITY OR TOWN <b>Lakeland</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <b>F</b> 6. RACE <b>N</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>7/29/83</b>		9. AGE (In years last birthday) <b>85</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Seamstress</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>			13. FATHER'S NAME <b>Louis Litz</b>		
14. MOTHER'S MAIDEN NAME <b>Sally DUFFY</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>215-05-1270</b>			17. INFORMANT <b>Mr. Robert Mantell, 2708 Huron Street 21230</b>		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial INFARCTION 30 min.</b>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>arterio-sclerotic cardiovascular disease</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>11/17/69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CATARACT</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE OLD INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>11/15/69</b> 19 <b>69</b> to <b>11/19</b> 19 <b>69</b> that (1) (we) last saw the deceased alive on <b>11/19</b> 19 <b>69</b> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Robert L. Kasper MD</b>				23B. DATE SIGNED <b>11/19/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>ROBERT L. KASPER MD</b>				23D. ADDRESS <b>UNIV. OF MD HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1-22-69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>	
24D. LOCATION <b>Burial</b>		24E. LOCATION <b>Glen Burnie, Anne Arundel Co., Md.</b>		24F. LOCATION <b>Glen Burnie, Anne Arundel Co., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Hubbard</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>	

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FUNERAL DIRECTOR: IMPORTANT

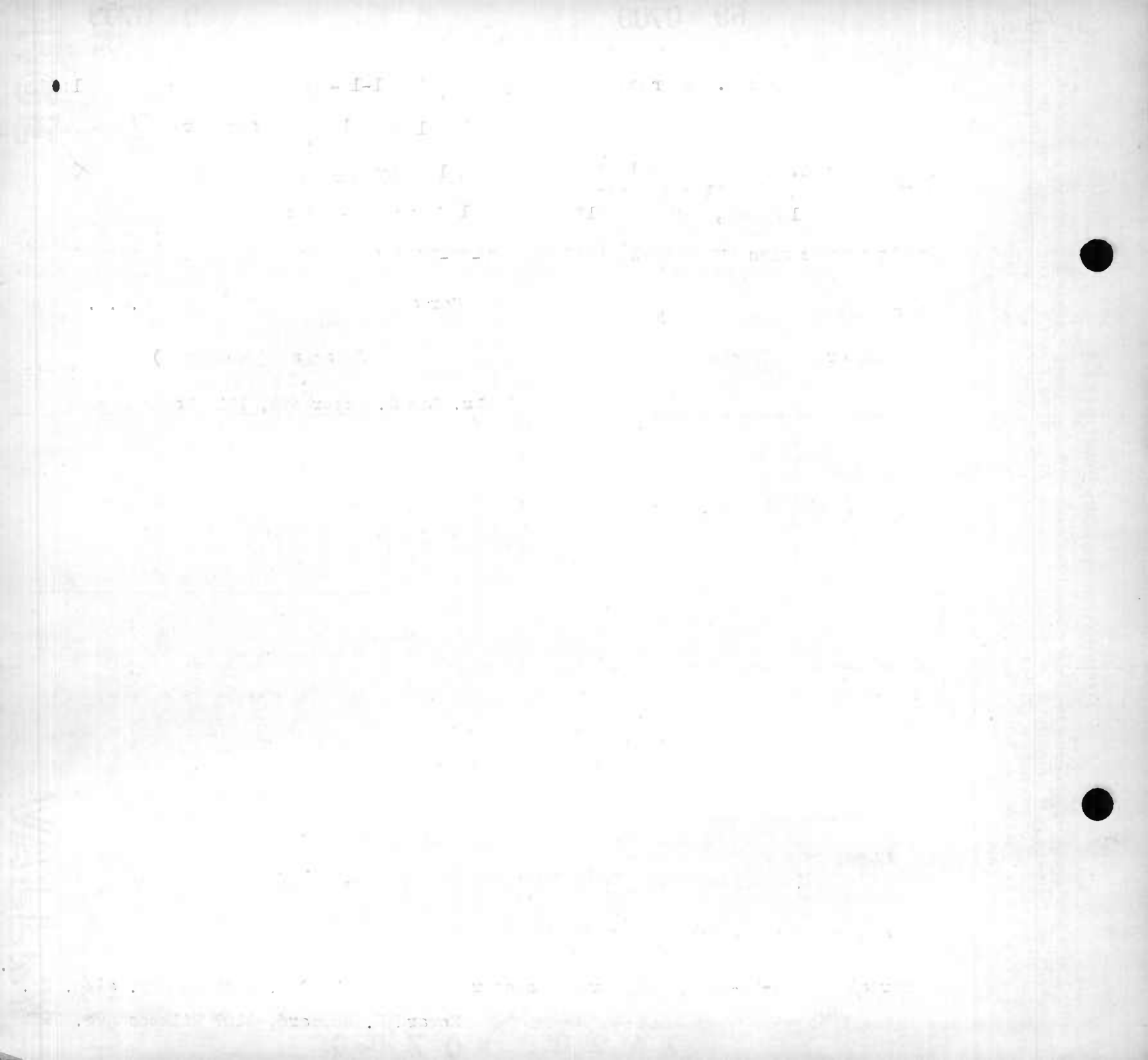
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0709

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 0709

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Marie G. Otterbein		1-18-69 1:05 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
40		St. Agnes Hospital Caton & Wilkens Avenue Baltimore, Maryland 21229		Maryland #21227 Baltimore 53-00	
5. SEX		6. RACE		C. CITY OR TOWN	
Female		Caucasian		Baltimore	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years last birthday)		E. STREET AND NUMBER	
7-28-84		84		1324 Maple Avenue	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Germany	
12. CITIZEN OF WHAT COUNTRY?		U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
Albert Jonske				Johanna (Unknown)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				21227	
		Mr. Leo A. Otterbein, 1324 Maple Avenue			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		acute myocardial infarction + Cardiogenic shock			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		Cardiovascular disease			
		(C) _____			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from (10:25 AM) 1-18-1969 to (1:30 PM) 1-18-1969, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
A. Shams Pirzadeh M.D.				1-18-69	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
A. SHAMS PIRZADEH, M.D.		St Agnes Hospital, 21229 Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		1-21-1969		Holy Cross Cemetery	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)			
6020 Gov. Ritchie Hwy, Balto. Co.		Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 21 1969		Robert E. Taylor		Howard H. Hubbard, 4107 Wilkens Ave. 21229	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 0710

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>EDWARD HOPKINS</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>January 15, 1969</b> Hour <b>11:30 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>CERTIFICATE AMENDED</b> <b>Baltimore City Hospital 1-28-69</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 15, 1969 11:30 A.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
9. DATE OF BIRTH <b>Nov. 3, 1912</b>		10. AGE (In years lost birthday) <b>56</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF <b>U.S.A.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tile-Setter</b>		148. KIND OF BUSINESS OR INDUSTRY <b>Ba-Mor Co.</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>219-01-3763</b>	
18. INFORMANT <b>Anna B. Hopkins</b>		ADDRESS <b>Same.</b>	

19. CAUSE OF DEATH <b>Pulmonary emboli</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Multiple blunt injuries</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
20A. DATE OF OPERATION <b>12-28-68</b>	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Fracture of tibia</b>	21. AUTOPSY? (Yes or No) <b>Yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>	22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Eastern Blvd. 20' west of Helena Blvd.</b>
22D. TIME OF INJURY (APPROX.) <b>12-28-68 7:20 PM</b>	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	22F. HOW DID INJURY OCCUR? <b>Pedestrian struck by auto</b>

23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED <b>January 16, 1969</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1-20-69.</b>	24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith</b>	24D. LOCATION (City, town, or county) (State) <b>Kenwood Ave. &amp; Trumps Mill Rd., Md</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1969</b>	25B. NAME OF REGISTRAR <b>Robert E. Feiberg, Jr.</b>	25C. FUNERAL DIRECTOR <b>Charles S. Geiler</b>	ADDRESS <b>6224 Eastern Ave. Balto., 21224, Md.</b>

VALLEY FORCE

CERTIFICATE

1-28-69

BY [illegible]

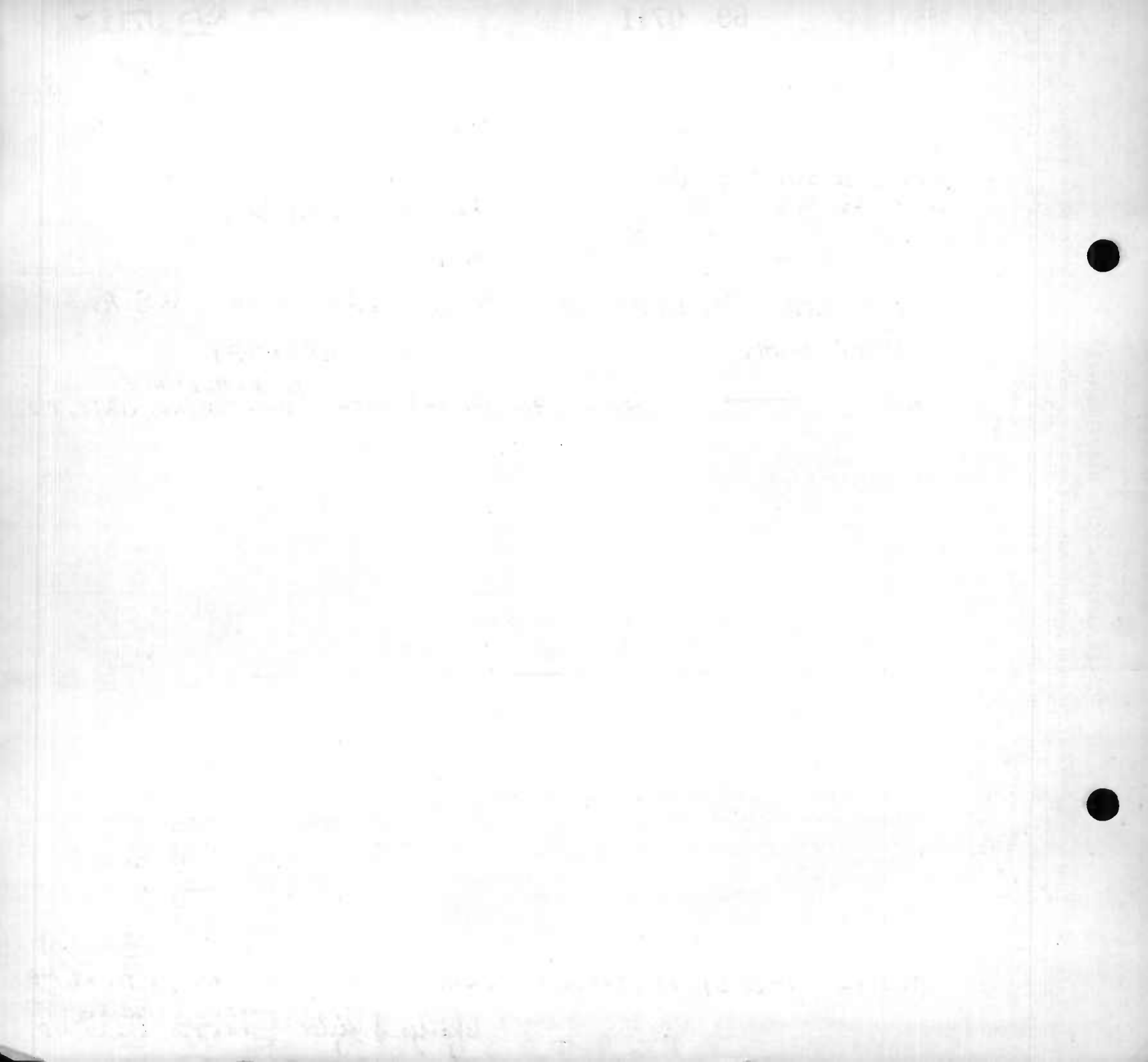
**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0711 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 69 0711

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Raymond W. Smith</u>		2. DATE AND HOUR OF DEATH <u>11/16/69</u> <u>5:10</u> <u>A.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>13-02</u>		C. CITY OR TOWN <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland Gen. Hospital</u> <u>Baltimore, Md.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>2266 Brookfield Ave.</u>	
5. SEX <u>Male</u>	6. RACE <u>Can.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/7/18</u>	9. AGE (In years lost birthday) <u>50</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNEMPLOYED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>LABORER</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland, BALTIMORE.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Frank Smith</u>		14. MOTHER'S MAIDEN NAME <u>MARY BRANSBY</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-03-5410</u>		17. INFORMANT ADDRESS <u>THELMA F. SMITH</u> <u>3701 ELMLEY AVE.</u> <u>BALTIMORE, 21213, MD.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>PULMONARY EDEMA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CIRRHOSIS OF LIVER</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C).....		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11/13</u> 19 <u>69</u> to time of death 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>11/16</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>M.C. Schmidt, M.D.</u> OEGREE				23B. DATE SIGNED <u>11/16/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>M.C. Schmidt M.D.</u> OEGREE				23D. ADDRESS <u>Maryland Gen. Hosp. Baltimore</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-20-69</u>		24C. NAME OF CEMETERY or CREMATORY <u>ST. STANISLAUS CEM.</u>	
24D. LOCATION <u>6515 BOSTON AVE. BALTO., 24, MD.</u>		24E. NAME OF REGISTRAR <u>Robert E. Fairbank</u>		24F. FUNERAL DIRECTOR <u>Charles J. Seiler</u>	
24G. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1969</u>		24H. NAME OF REGISTRAR <u>Robert E. Fairbank</u>		24I. ADDRESS <u>901 S. CONKLING ST. BALTO., 21224, MD.</u>	





## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

## 69 0712 CERTIFICATE OF DEATH

REG. NO. 69 0712

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Raymond T. Divick

2. DATE AND HOUR OF DEATH

Jan 16, 1969 1:45 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☒NO ☐

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospital  
4940 EASTERN AVENUE BALTIMORE, MARYLAND

E. STREET AND NUMBER

503 S. PONCA STREET 21224

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

3-16-16

9. AGE (In years lost birthday)

52

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

SILAS DIVICK

14. MOTHER'S MAIDEN NAME

HILDA

15. Was Deceased Ever in U. S. Armed Forces?

YES

WW II

16. SOCIAL SECURITY NO.

218-07-8673

17. INFORMANT

21224

ADDRESS

BCH: RECORDS 4940 EASTERN AVE. BALTO. MD.

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

Staphylococcal pneumonia

3 days

(B) Delerium tremens  
DUE TO, OR AS A CONSEQUENCE OF:

acute and chronic alcoholism

4 days

(C) 10 yrs +

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 11 19 69 to Jan 16 19 69, that (I) (we) last saw the deceased alive on Jan 16 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Hubert W. Gerry M.D.

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

Jan 16, 1969

23C. PHYSICIAN'S NAME (Type)

Hubert W. Gerry M.D.

DEGREE

23D. ADDRESS

4940 Eastern Ave Balt. Md. 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

1/20/69

24C. NAME OF CEMETERY or CREMATORY

BALTO. NATL. CEM.

24D. LOCATION

BALTO. MD.

(City, town, or county)

(State)

25A. DATE REC'D. BY HEALTH DEPT.

25B. NAME OF REGISTRAR

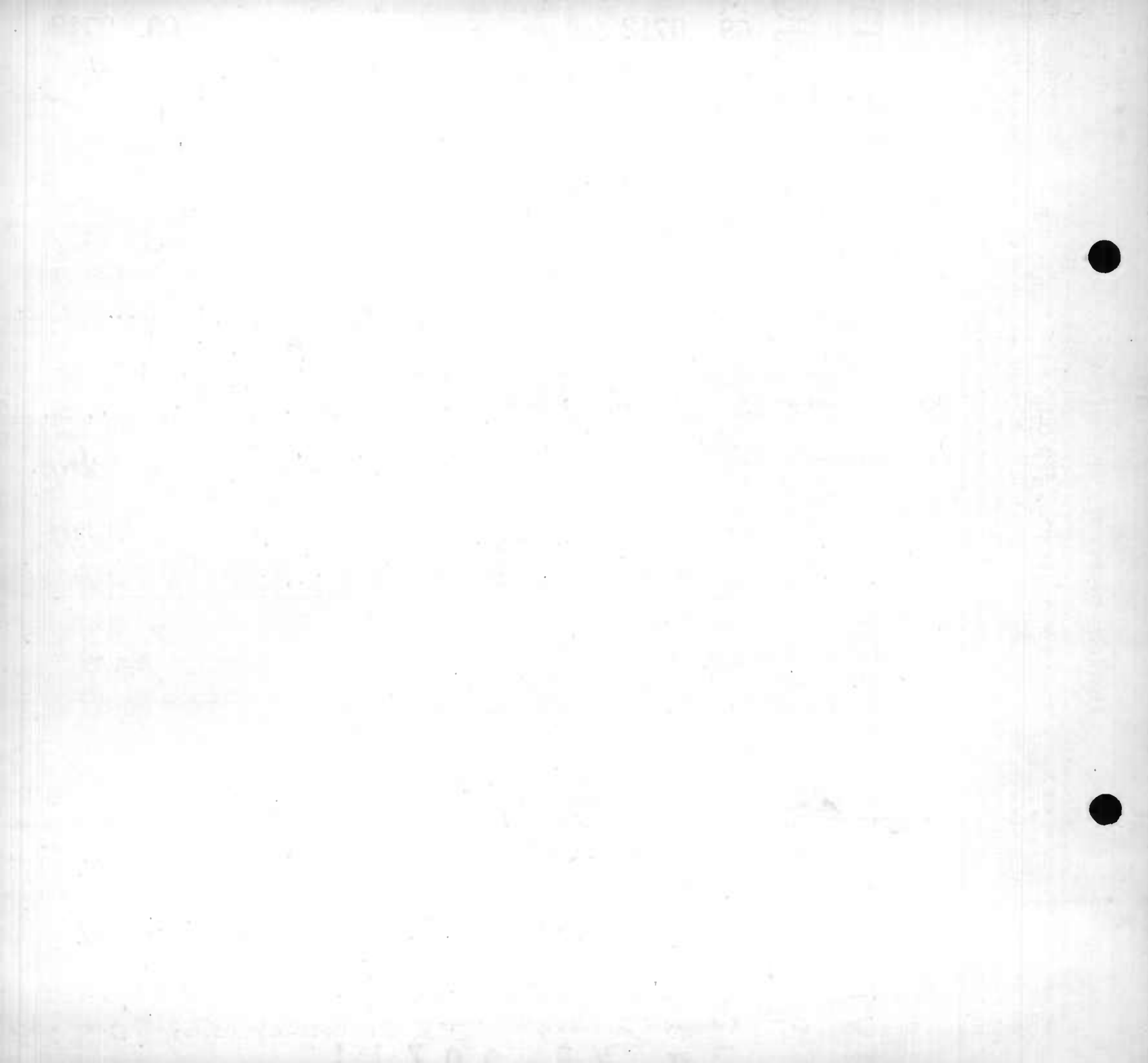
Hubert W. Gerry

25C. FUNERAL DIRECTOR

J.E. CONNELLY SONS

ADDRESS

300 MACE



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0713

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

69 0713

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ERNEST LITTLE

2. DATE AND HOUR OF DEATH

1/17/69 1245 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

MERCY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution's residence before admission)

A. STATE

B. COUNTY

MD.

BALTO

53-00

C. CITY OR TOWN

ESSEX

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

1733 GLEN CURTIS RD

5. SEX

M

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

09/13/02

9. AGE (In years last birthday)

66

If Under 1 Yr.

Months

If Under 24 Hrs.

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

RETIRED

11. BIRTHPLACE (State or foreign country)

PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

WALTER LITTLE

14. MOTHER'S MAIDEN NAME

ANNIE CROMWELL

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

UNK

16. SOCIAL SECURITY NO.

194-09-0833

17. INFORMANT

RUTH LITTLE ABOVE

ADDRESS

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

CVA, brain tumor

(B) DUE TO, OR AS A CONSEQUENCE OF:

Renal failure, uremia

(C) Metastatic bronchogenic Ca

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (This hospital) attended the deceased from 12-30 1968 to 1-17 1969 that (I) lost saw the deceased alive on 1-17 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.

23A. SIGNATURE

Manuela Ribeiro

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1-17-69

23C. PHYSICIAN'S NAME (Type)

MANUELA RIBEIRO, M.D.

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)

REMOVAL

24B. DATE

1/19/69

24C. NAME OF CEMETERY or CREMATORY

GRANDVIEW

24D. LOCATION

(City, town, or county)

(State)

SAXTON PT

25A. DATE REC'D BY HEALTH DEPT.

JAN 21 1969

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

J.G. CONNELLY SONS

ADDRESS

300 MACE

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1891

1

OFFICE OF THE  
COMMISSIONER OF THE LAND OFFICE

ALBANY, N. Y.

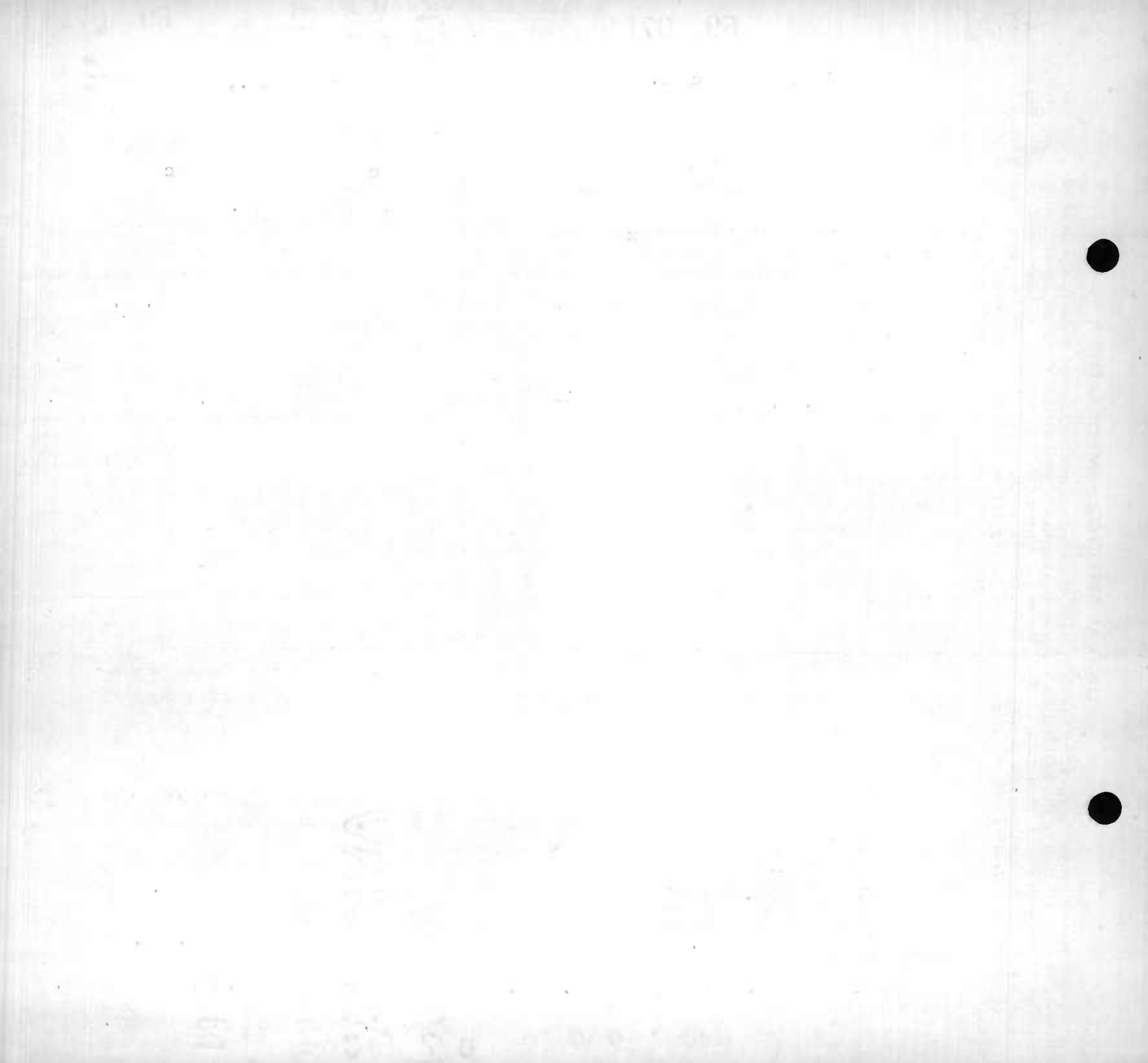
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 69 0714 CERTIFICATE OF DEATH

REG. NO.

69 0714

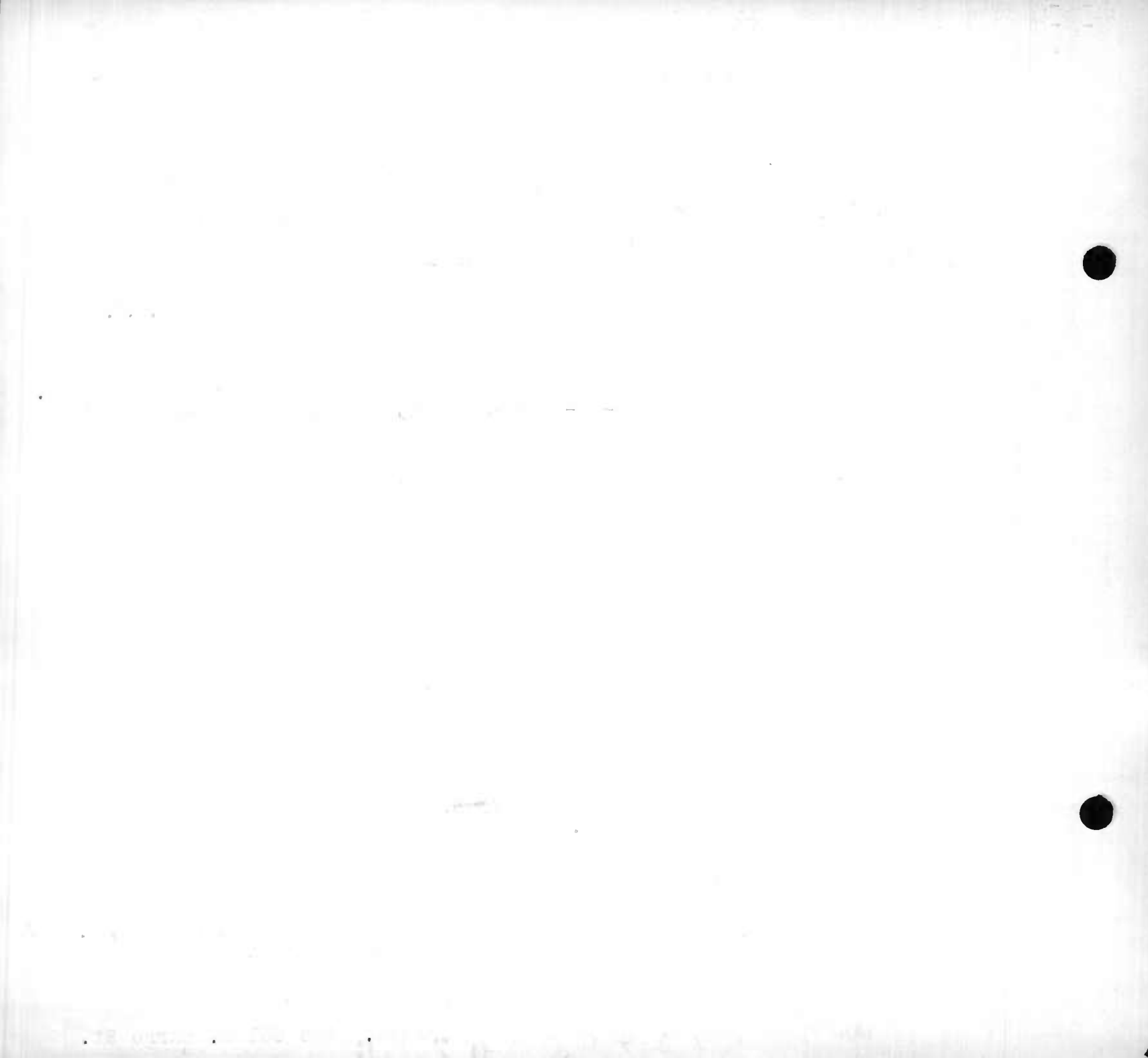
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Dolle, Frederick C.</b>		2. DATE AND HOUR OF DEATH <b>January 15th., 1969   2:32 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>25-72</b>		C. CITY OR TOWN <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>40 Saint Agnes Hospital Caton &amp; Wilkens Aves. 21229</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>2310 W. Patapsco Ave.</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/8/96</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Stopper Grinder</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Glass Co.</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13. FATHER'S NAME <b>Rudolph Dolle</b>		14. MOTHER'S MAIDEN NAME <b>Ametia Heyl</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W. W. I</b>		16. SOCIAL SECURITY NO. <b>216-05-5199</b>		17. INFORMANT ADDRESS <b>Mrs. Minnie Dolle 2310 W. Patapsco Ave.</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslhenio, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>Arteriosclerotic Cardiovascular Disease</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>19 minutes</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>June 1, 1964</b> to <b>January 15, 1969</b> , that (I) (we) lost saw the deceased alive on <b>January 15, 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Morris M. Steinberg M.D.</b>		23B. DATE SIGNED <b>Jan. 16, 1969</b>		23C. PHYSICIAN'S NAME (Type) <b>Morris M. Steinberg MD</b>	
23D. ADDRESS <b>3913 Hollins Ferr Rd. Balto. Md. 21230</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>Jan. 18, 1969</b>		24C. NAME OF CEMETERY or CREMATORY <b>Balto. Nat. Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Frederick Rd. Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1969</b>		25B. NAME OF REGISTRAR <b>George J. Gonce</b>		25C. FUNERAL DIRECTOR ADDRESS <b>4001 Ritchie Hwy. (21225)</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
H-252		69 0716		69 0716	
1. NAME OF DECEASED (Type or Print) <b>Delores Hawkins</b>			2. DATE AND HOUR OF DEATH <b>JAN. 19, 1969</b> <b>1 45 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>26-12</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BALTIMORE CITY HOSPITALS 21224</b> <b>4940 Eastern Avenue, Baltimore, Maryland</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>Female</b>			6. RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>8-25-1927</b>
13. FATHER'S NAME <b>Earl Smith</b>			14. MOTHER'S MAIDEN NAME <b>Hilda Spence</b>		9. AGE (In years last birthday) <b>41</b>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>218-29-1215</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
17. INFORMANT <b>Charles Hawkins 1335 Ward St. Records: BGM-4940 Eastern Avenue 21224</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>430.91</b> <b>CAUSE OF DEATH</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <b>PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF:		
			(B) <b>DEBILITATION</b> DUE TO, OR AS A CONSEQUENCE OF:		
			(C) <b>SUBARACHNOID HEMORRHAGE</b> DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>July 5, 1963</b> to <b>JAN. 19, 1969</b> that (I) (we) last saw the deceased alive on <b>Jan. 19, 1969</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Joseph Kaplan M.D.</b>				23B. DATE SIGNED <b>1/19/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Joseph Kaplan</b>				23D. ADDRESS <b>4940 Eastern Avenue, Baltimore, Md. 21224</b> <b>Baltimore City Hospitals</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-23-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>	
24D. LOCATION <b>Baltimore, Md</b>		24E. NAME OF REGISTRAR <b>JAN 21 1969</b>		24F. FUNERAL DIRECTOR <b>Charles A. Rice 661 W. Barre St.</b>	

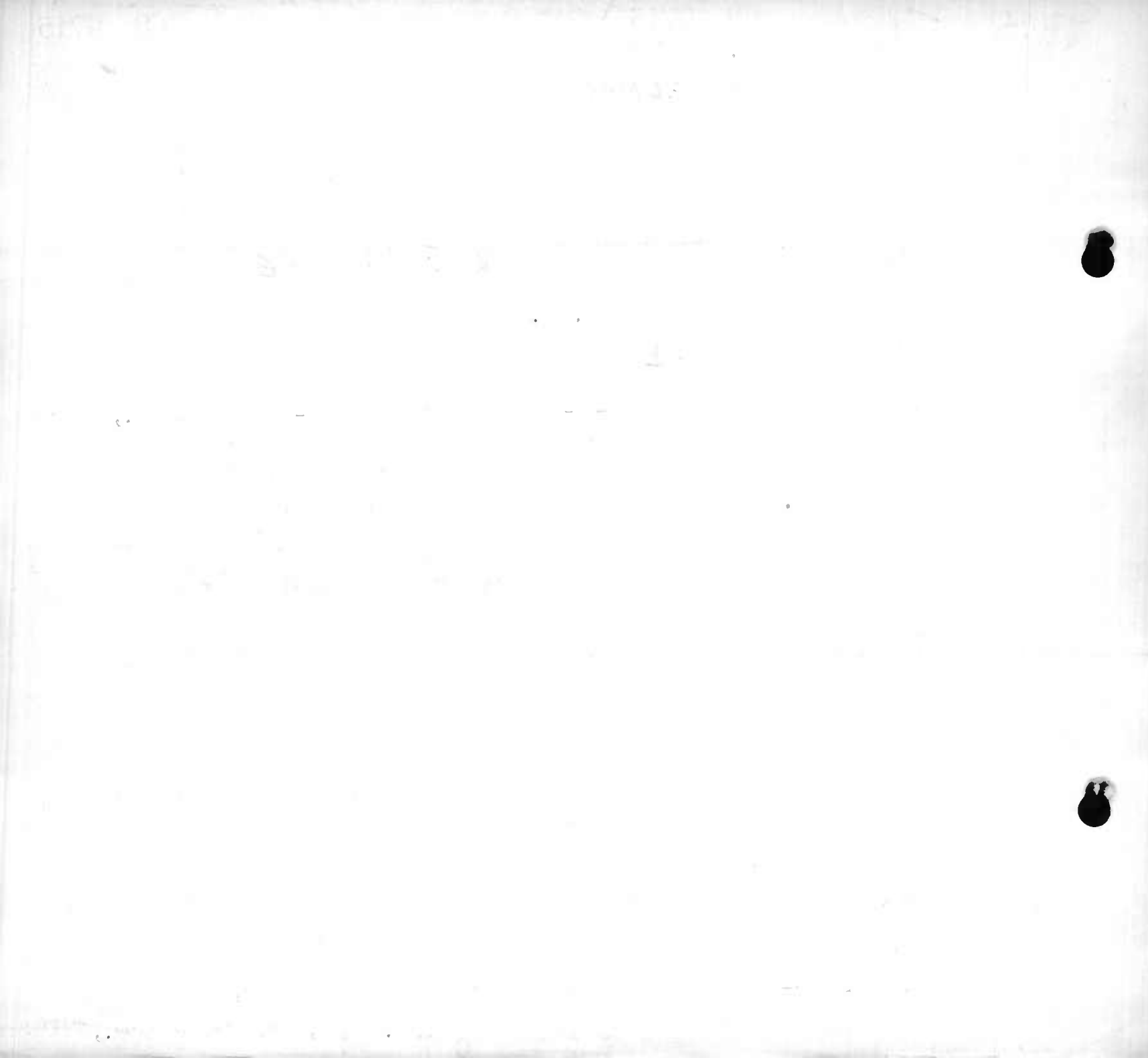




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

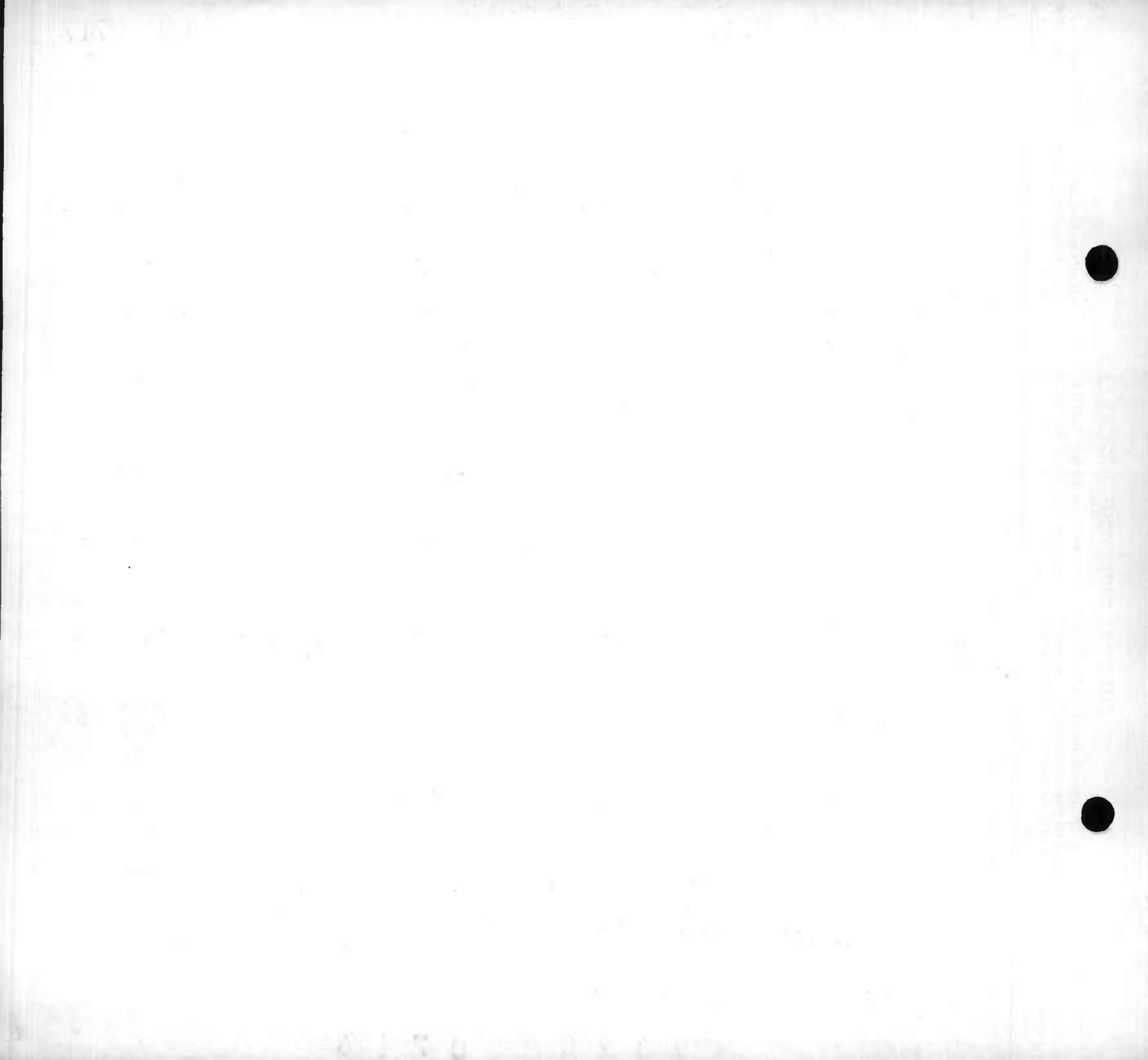
69 0715 BALTIMORE CITY HEALTH DEPARTMENT		69 0715	
BIRTH NO. JOHN J. COPPELMAN		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>JOHN COPPELMAN</b>		2. DATE AND HOUR OF DEATH <b>JAN. 13, 1969, 6:00 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>FRANKLIN SQUARE HOSP.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>25-53</b>	
		C. CITY OR TOWN <b>BALTIMORE.</b>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <b>2212 MAISEL ST.</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-5-82</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watchmen</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Gas &amp; Elec. Co.</b>	9. AGE (In years lost birthday) <b>86</b>
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CHARLES COPPELMAN</b>		14. MOTHER'S MAIDEN NAME <b>HERSA MYERS</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-05-4661</b>	
		17. INFORMANT <b>Marion Coppelman - 25 Bristol Ave., Baltimore</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Acute bronchopneumonia,</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>NEW YORK</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.  <b>II</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>massive bilateral secondary</b>	
		(B) <b>to regenerative arteriosclerosis.</b>	
		(C) <b>Myocardial infarction, remote.</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>2</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>	20A. AUTOPSY? (Yes or No) <b>YES</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1-12-69</b> to <b>1-13-69</b> that (I) (we) last saw the deceased alive on <b>1-13-69</b> and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>SUNAN VONGKASEMSIRI</b>			23B. DATE SIGNED <b>JAN 13, 69</b>
23C. PHYSICIAN'S NAME (Type) <b>SUNAN VONGKASEMSIRI</b>			23D. ADDRESS <b>F.S.H.</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1-17-1969</b>	24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1969</b>	25B. NAME OF REGISTRAR <b>George J. Gonce</b>	25C. FUNERAL DIRECTOR <b>George J. Gonce, 4001 Ritchie Hgwy., Baltimore</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
69 0717		69 0717		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Wimmer Evelyn		JAN 17 '69 11:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 13 South Baltimore General Hospital		A. STATE Maryland		B. COUNTY 24-03	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 125 E. Clement St. 21230			
5. SEX female	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/28/06	9. AGE (in years last birthday) 61	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self beautician		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VA	
13. FATHER'S NAME Robert King		14. MOTHER'S MAIDEN NAME Mary Dewey		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT chart	
				ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 398X1		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary heart failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several weeks	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Rheumatic heart disease		Several years	
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		pneumonia, pleural effusion		Several weeks	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 1/15/69 to 1/17/69 that (1) (we) last saw the deceased alive on 1/17/69 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sung Yoon Shin, M.D.				23B. DATE SIGNED 1/17/69	
23C. PHYSICIAN'S NAME (Type) SUNG YOUNG SHIN				23D. ADDRESS South Baltimore General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-22-69		24C. NAME OF CEMETERY OR CREMATORY Sherwood Cem.	
				24D. LOCATION (City, town, or county) (State) ROANOKE, VA.	
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1969		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Wm. J. TUCKNER & SON - BALTO, MD	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 0718
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Purviance, Florence</b>		2. DATE AND HOUR OF DEATH <b>1-15-69</b> <b>745 P</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md</b> B. COUNTY <b>17-10</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Bolton Hill Nsg Home</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>5310 Kenilworth Avenue</b>		
5. SEX <b>F</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/16/84</b>	9. AGE (In years lost birthday) <b>84</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher - Ret</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>		11. BIRTHPLACE (State or foreign country) <b>Md, Baltimore</b>	
13. FATHER'S NAME <b>Peter Purviance</b>			14. MOTHER'S MAIDEN NAME <b>Hanna Jane ?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, na at unknown) (If yes, give war at dates of service)		16. SOCIAL SECURITY NO. <b>818-36-1687</b>		17. INFORMANT <b>Abstract</b>	
				ADDRESS <b>1400 John St.</b>	
18. <b>412.51</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebral Thrombosis</b> (B) <b>old lxp pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>arteriosclerotic heart disease</b> <b>arteriosclerotic generalized</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>11/68</b> <b>years</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/18 1965</b> to <b>1/15 1969</b> , that (I) (we) last saw the deceased alive on <b>1/15 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b>			23B. DATE SIGNED <b>1/16/69</b>		Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <b>ALLAN H. MACHT MD</b>			23D. ADDRESS <b>2 E. READ ST Baltimore</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/20/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mount Auburn Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Herbert E. Nutter-3035 W. North Ave.</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JAMES PERKINS</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year <b>January 16, 1969</b>		Hour <b>5:37 A.</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Lutheran Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>January 16, 1969</b>		Hour <b>5:37 A.</b>
6. SEX <b>Male</b>		7. RACE <b>Negro</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH <b>March 25, 1914</b>		10. AGE (In years last birthday) <b>54</b>		11. BIRTHPLACE (State or foreign country) <b>Bel Haveh, Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>James Perkins</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Handler</b>
15. MOTHER'S MAIDEN NAME <b>Maggie Stock</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>217-05-8945</b>
18. INFORMANT <b>Mrs. Martha E. Perkins-3126 Windsor Ave.</b>		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of lung</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>No</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>January 16, 1969</b>
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Jan. 21, 1969</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore Co. Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1969</b>		25B. NAME OF REGISTRAR <b>Herbert E. Nutter-3035 W. North Ave.</b>
25C. FUNERAL DIRECTOR		25D. ADDRESS		





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 0720

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ROSALIE ROBINSON</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>1 12 69 2:40 p M.</b>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>00 1339 N. Carey St.</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 12, 1969 2:40 p.m.</b>			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-01</b>							
6. SEX <b>Female</b>	7. RACE <b>Colored</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>10/23/1912</b>		10. AGE (In years last birthday) <b>56</b>		E. STREET AND NUMBER <b>1339 N. Carey St.</b>			
11. BIRTHPLACE (State or foreign country) <b>Caroline Co. Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Lewis Thornton</b>			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>Patsy Buckner</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>217-20-8288</b>		18. INFORMANT ADDRESS <b>Mrs. Rosa Brooks -2103 Clifton Ave.</b>			
19. <b>796.91</b> CAUSE OF DEATH <b>Undetermined due to</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Decomposition</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE</b> <b>DETO, OR AS A CONSEQUENCE OF:</b> <b>(B) DETO, OR AS A CONSEQUENCE OF:</b> <b>(C) DETO, OR AS A CONSEQUENCE OF:</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Myocardial scarring</b>							
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE <i>Edward F. Wilson</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> <b>1/13/69</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/18/1969</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1969</b>		25B. NAME OF REGISTRAR <b>Herbert E. Nutter</b>		25C. FUNERAL DIRECTOR ADDRESS <b>3035 W. North Ave.</b>			

1970 RA

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WILLIAM E. BOHLEN  
SECRETARY OF DEFENSE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0721

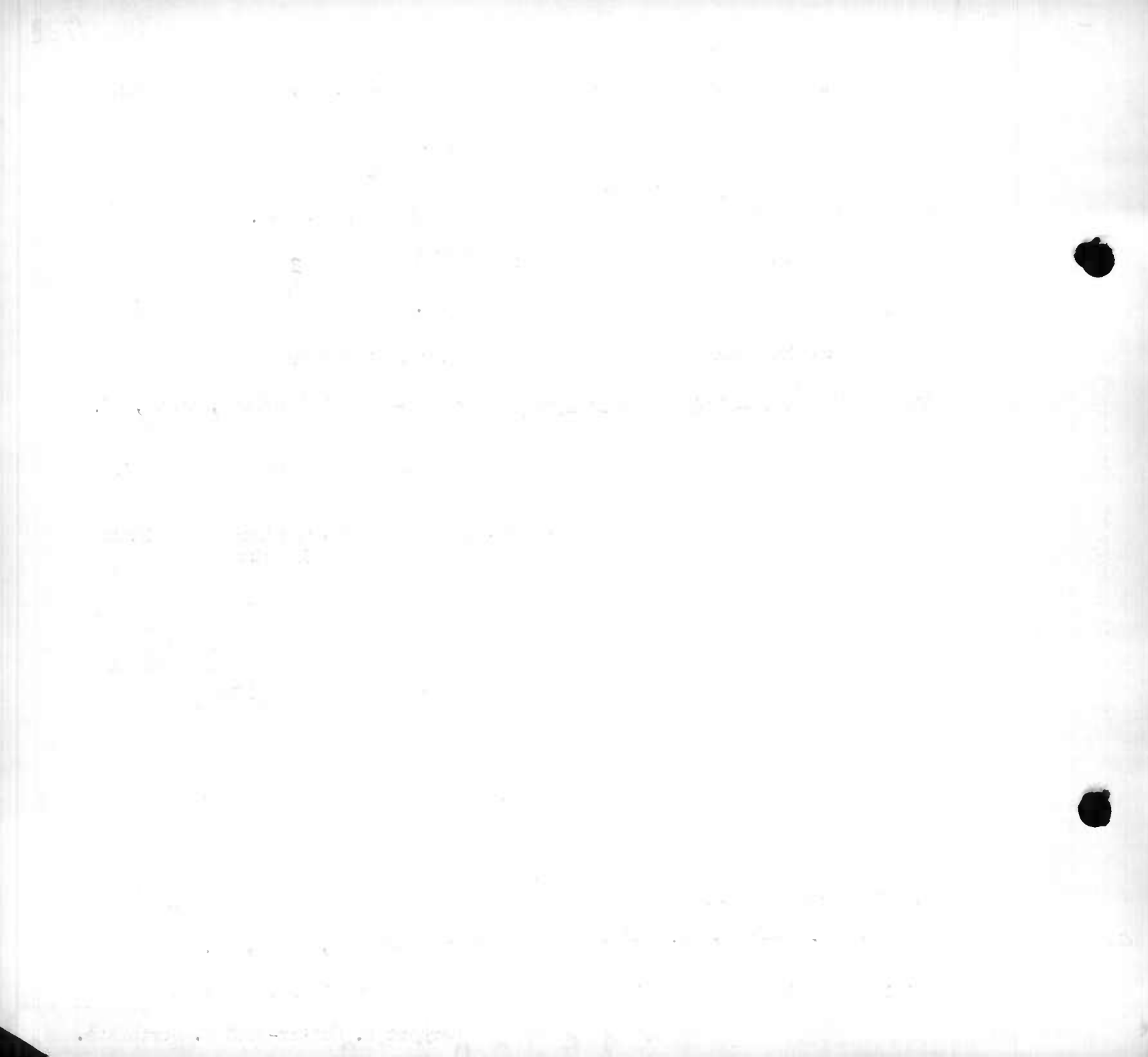
BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

REG. NO.

69 0721

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>John Lawrence Grinnell</b>		2. DATE AND HOUR OF DEATH <b>Jan. 15, 1969 2:30 A.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>US Public Health Service Hospital 3100 Wyman Parkway</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>16-01</b>	
5. SEX <b>M</b>		6. RACE <b>Col</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH <b>7/22/85</b>		9. AGE (In years last birthday) <b>83</b>		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>USA</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Sanford Grinnell</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Greecy</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>USA 1910-1944 527-30-5674</b>		17. INFORMANT ADDRESS <b>Records- US PHS Hospital, Balto, Md.</b>	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Myocardial infarction</b> <small>[This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.]</small>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic cardiovascular disease</b>				<b>Years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>DEAD ON ARRIVAL</b> 19 <b>1/15/69</b> to <b>19</b> that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>M. Bellamy</b>				23B. DATE SIGNED <b>1/16/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Murlyn D. Bellamy, Sr. Surgeon</b>				23D. ADDRESS <b>US PHS Hospital, Balto, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/20/69</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1969</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Herbert E. Nutter-3035 W. North Ave.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

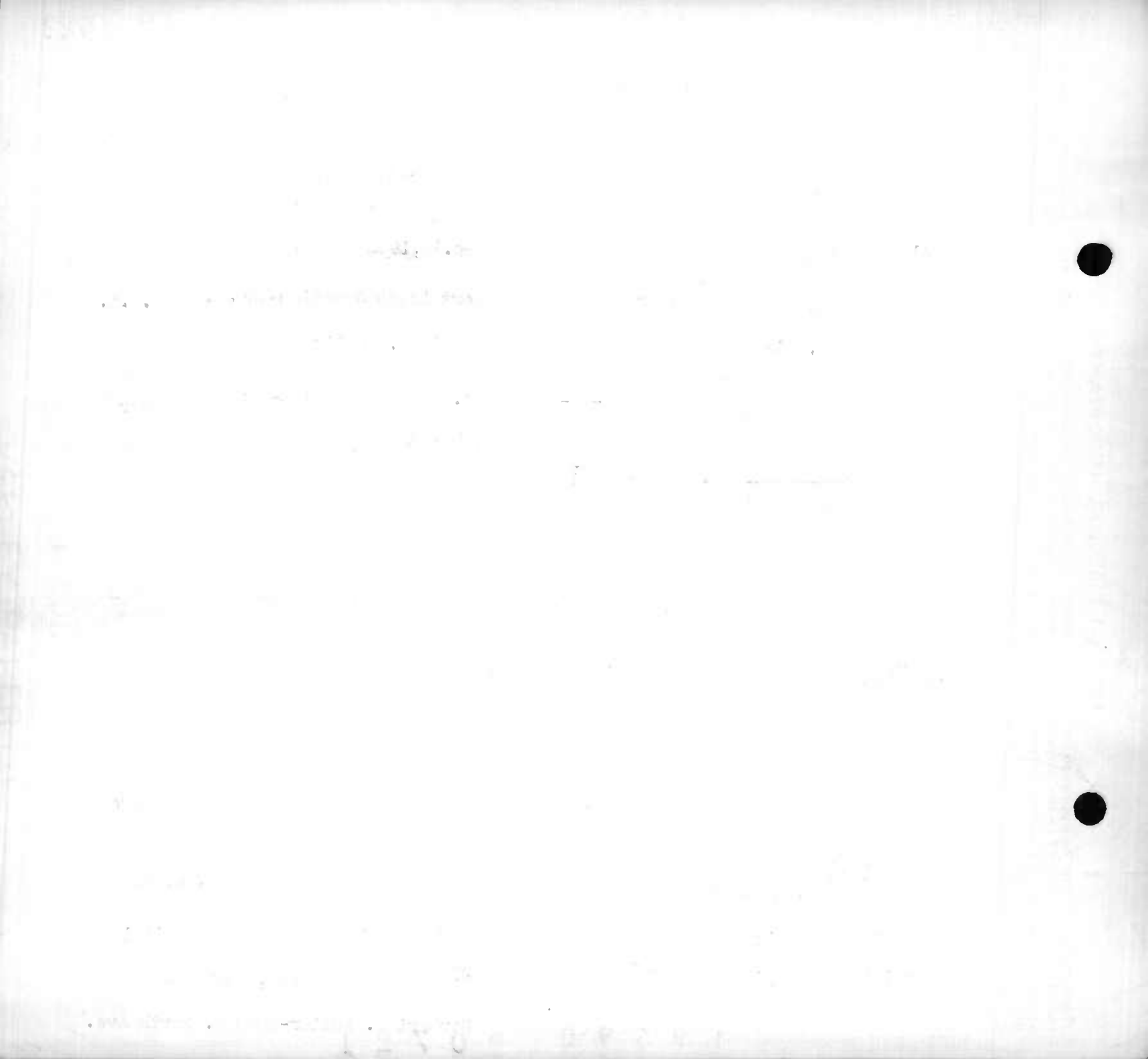
69 0722

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

69 0722

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Thomas Simms</i>		2. DATE AND HOUR OF DEATH <i>11/12/69 2:40</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Harford CO.</i>		M. <i>63-00</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>1350 SOUTH BALTIMORE GENERAL HOSPITAL</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Hanover Maryland</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>Male</i>		6. RACE <i>Negro</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>Dec. 16, 1900</i>		9. AGE (In years, last birthday) <i>68</i>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Farmer</i>		11. BIRTHPLACE (State or foreign county) <i>Fort Meade Junction-AA CO.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Thomas K. Simms</i>		14. MOTHER'S MAIDEN NAME <i>Mamie E. Dublin</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>216-67-0907</i>		17. INFORMANT ADDRESS <i>Mrs. Dorothy Braxton-Box 17 Race Road Hanover Maryland</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>4449 I POSSIBLE PULMONARY EMBOLISM POSSIBLE COMPRESSIVE VESSEL</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>DERMATITIS POSSIBLE INFLAMMATORY ARTERITIS SUBCUTANEOUS EXPOSURE TO RADIATION</i>					
19A. DATE OF OPERATION <i>11/11/69</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>AVILLARY</i>		20A. AUTOPSY? (Yes or No) <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Indicate medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11/11/69</i> to <i>11/12/69</i> and that (I) (we) last saw the deceased alive on <i>11/12/69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i> MD DEGREE				23B. DATE SIGNED <i>1/12/69</i>	
23C. PHYSICIAN'S NAME (Type) <i>Steven Manekin MD</i>				23D. ADDRESS <i>South Baltimore General Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/17/69</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Saints Rest Cemetery</i>	
24D. LOCATION (City, town, or county) <i>Harmans, Maryland</i>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 21 1969</i>		25B. NAME OF REGISTRAR <i>[Signature]</i>		25C. FUNERAL DIRECTOR <i>Herbert E. Nutter-3035 W. North Ave.</i>	



**FUNERAL DIRECTOR: IMPORTANT**

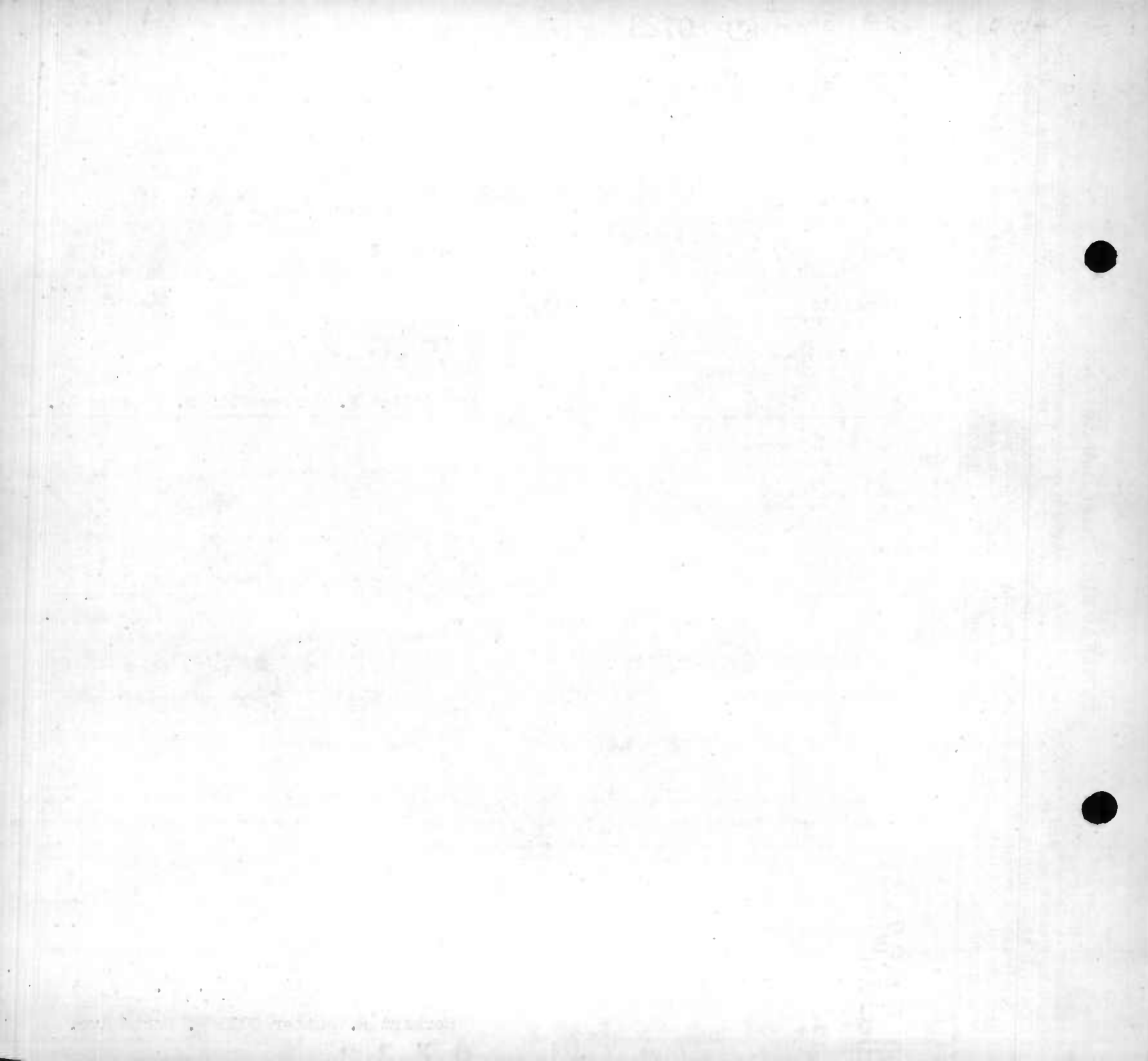
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0723

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

REG. NO. 69 0723

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Naomi Dorsey</b>		2. DATE AND HOUR OF DEATH <b>1-12-69 12:30 A</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>38 University of Md Hosp</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>2568 W. Fayette St</b>		5. SEX <b>F</b> 6. RACE <b>N</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Private Family</b>		B. DATE OF BIRTH <b>3-2-92</b> 9. AGE (In years lost birthday) <b>76</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		11 Under 1 Yr. Months: Days: 11 Under 24 Hrs. Hours: Min.	
13. FATHER'S NAME <b>Joshua B. Williams</b>			14. MOTHER'S MAIDEN NAME <b>Febec Miller</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-36-0313</b>		17. INFORMANT ADDRESS <b>Mr William E. Dorsey 2568 W. Fayette St.</b>	
18. <b>41231</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Edema</b>				<b>3 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Coronary artery disease</b>	
				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>? Systemic angiodysplasia</b>	
				(C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Edema</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1-10</b> 19 <b>69</b> to <b>1-12</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>1-12</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Paul R. Spilberg M.D.</b>				23B. DATE SIGNED <b>1-12-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Paul R. Spilberg</b>				23D. ADDRESS <b>University Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/16/69</b>		24C. NAME of CEMETERY or CREMATORY <b>Western Star Cemetery</b>	
24D. LOCATION <b>Baltimore CO. MD.</b>		24E. DATE RECD. BY HEALTH DEPT. <b>JAN 21 1969</b>		24F. NAME OF REGISTRAR <b>Herbert E. Nutter</b>	
24G. FUNERAL DIRECTOR <b>Herbert E. Nutter</b>		24H. ADDRESS <b>3035 W. North Ave.</b>		24I. DATE <b>1-12-69</b>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
69 0724 CERTIFICATE OF DEATH

REG. NO. 665-3924

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Dowery, Gladys Marie</b>		2. DATE AND HOUR OF DEATH <b>1-17-69 2 15 PM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>1922 Druid Hill Ave</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 Dukeland Nursing Home</b> <b>1501 Dukeland Street</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>FEMALE</b>		6. RACE <b>NEGRO</b>		E. STREET AND NUMBER <b>1922 Druid Hill Ave. 14-03</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 9, 1901</b>		9. AGE (In years last birthday) <b>67</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher -Ret.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>James Nathaniel Turner</b>		14. MOTHER'S MAIDEN NAME <b>Emma G. Short</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-22-8353-A</b>		17. INFORMANT <b>Dukeland Nursing Home</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CEREBRAL ARTERIO SCLEROSIS</b>		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CEREBRAL ARTERIO SCLEROSIS</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from <b>8-12</b> 19 <b>66</b> to <b>1-13</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>1-13</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Thomas W. Harris</b>				23B. DATE SIGNED <b>1-17-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>THOMAS W. HARRIS</b>				23D. ADDRESS <b>4200 EDWARDS AVE</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/22/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. G. G. G.</b>		25C. FUNERAL DIRECTOR <b>Herbert E. Nutter-3035 W. North Ave.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0725		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 69 0725	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Wiggins, Susan F.</b>		2. DATE AND HOUR OF DEATH <b>11/12/69 8:15 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>-</b>		5. CITY OR TOWN <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hosp. of Baltimore</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <b>F</b>		7. RACE <b>N</b>		8. DATE OF BIRTH <b>12-9-84</b>	
9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		10. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <b>84</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic Work</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Private Family</b>		11. BIRTHPLACE (State or foreign country) <b>N.C.</b>	
13. FATHER'S NAME <b>Henry Fonville</b>		14. MOTHER'S MAIDEN NAME <b>Martha Prudence</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-54-1364T</b>		17. INFORMANT <b>Mrs Nancy Middleton 3905 Mondawmin Ave.</b>	
18. <b>18271</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE <b>Severe dehydration</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Vaginal bleeding (Probable Uterine Tumor)</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Possible carcinomatosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>1 day</b> <b>2 months</b>	
19A. DATE OF OPERATION <b>1-12-69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1-9</b> 19 <b>69</b> to <b>1-12</b> 19 <b>69</b> that (I) (we) last saw the deceased alive on <b>1/12</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Paul D. Krieger MD</b>		23B. DATE SIGNED <b>1-12-69</b>		23C. PHYSICIAN'S NAME (Type) <b>PAUL D. Krieger MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/15/69</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore CO. MD.</b>		25A. DATE DECEASED <b>JAN 21 1969</b>		25B. NAME OF REGISTRAR <b>Herbert E. Nutter</b>	
25C. FUNERAL DIRECTOR <b>Herbert E. Nutter</b>		25D. ADDRESS <b>3035 W. North Ave.</b>			

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69 0726 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

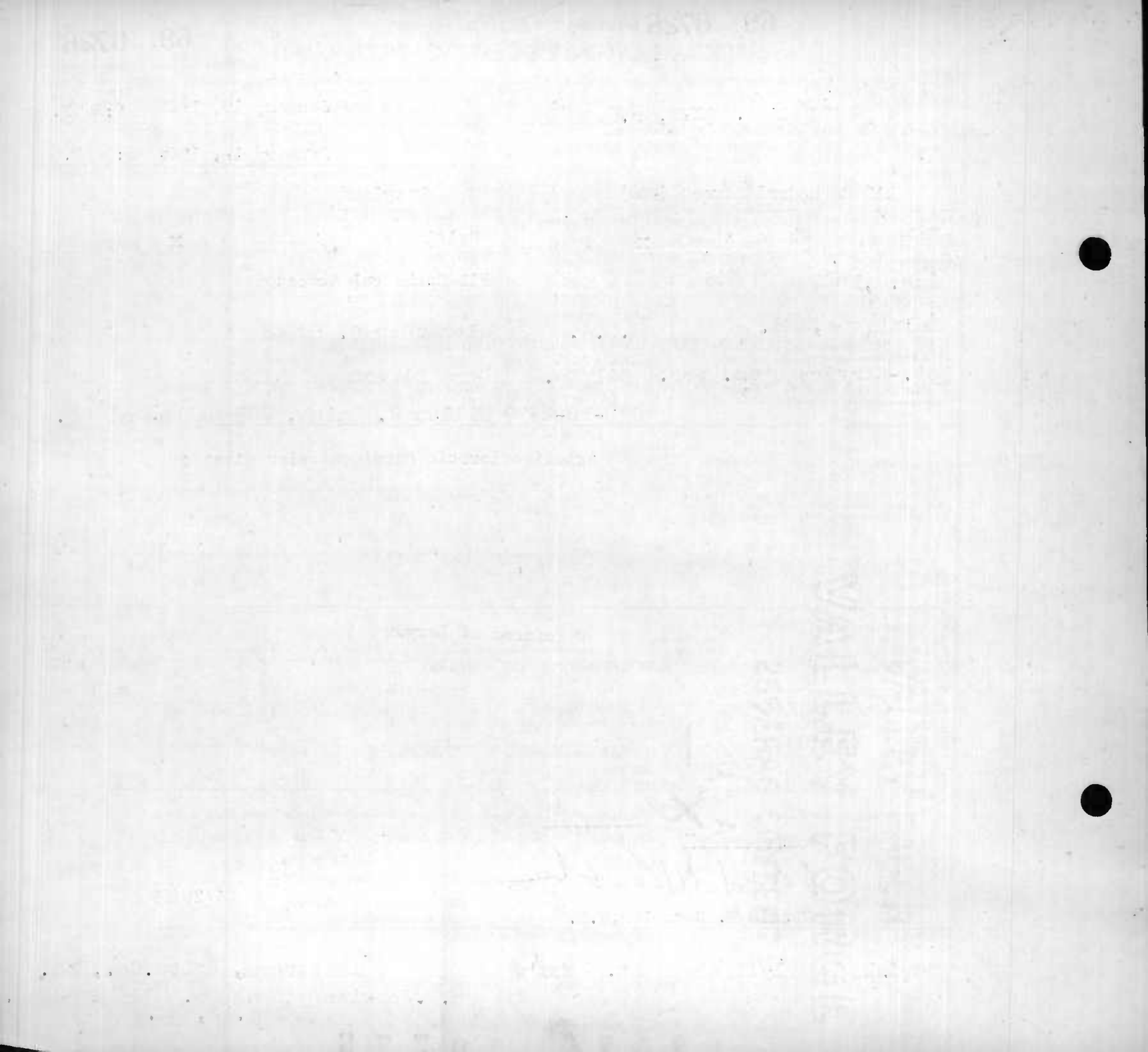
REG. NO.

69 0726

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>MARSHALL A. SMITH, Sr.</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>January 19, 1969</b> Hour <b>6:30 P. M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>712 Cathedral Street (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 19, 1969 6:30 P. M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Aug. 9, 1889</b>		10. AGE (In years lost birthday) <b>79</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret.-Service Stat. Oper. Oil Co.</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>American</b>	
15. MOTHER'S MAIDEN NAME <b>Dora Albert</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>035-16-2979</b>		18. INFORMANT <b>Hillen J. Smith, 703 Cathedral St.</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Carcinoma of Larynx</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
21. DATE OF OPERATION <b>1/22/69</b>		22. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>no</b>	
23A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		23B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
23C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		23D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
23E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		23F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED <b>1/20/69</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/22/69</b>	
24C. NAME of CEMETERY or CREMATORY <b>St. John's</b>		24D. LOCATION (City, town, or county) (State) <b>Longgreen, Balto. Co., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>	
25C. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>		25D. ADDRESS <b>4905 York Rd. Balto. 12, Md.</b>	

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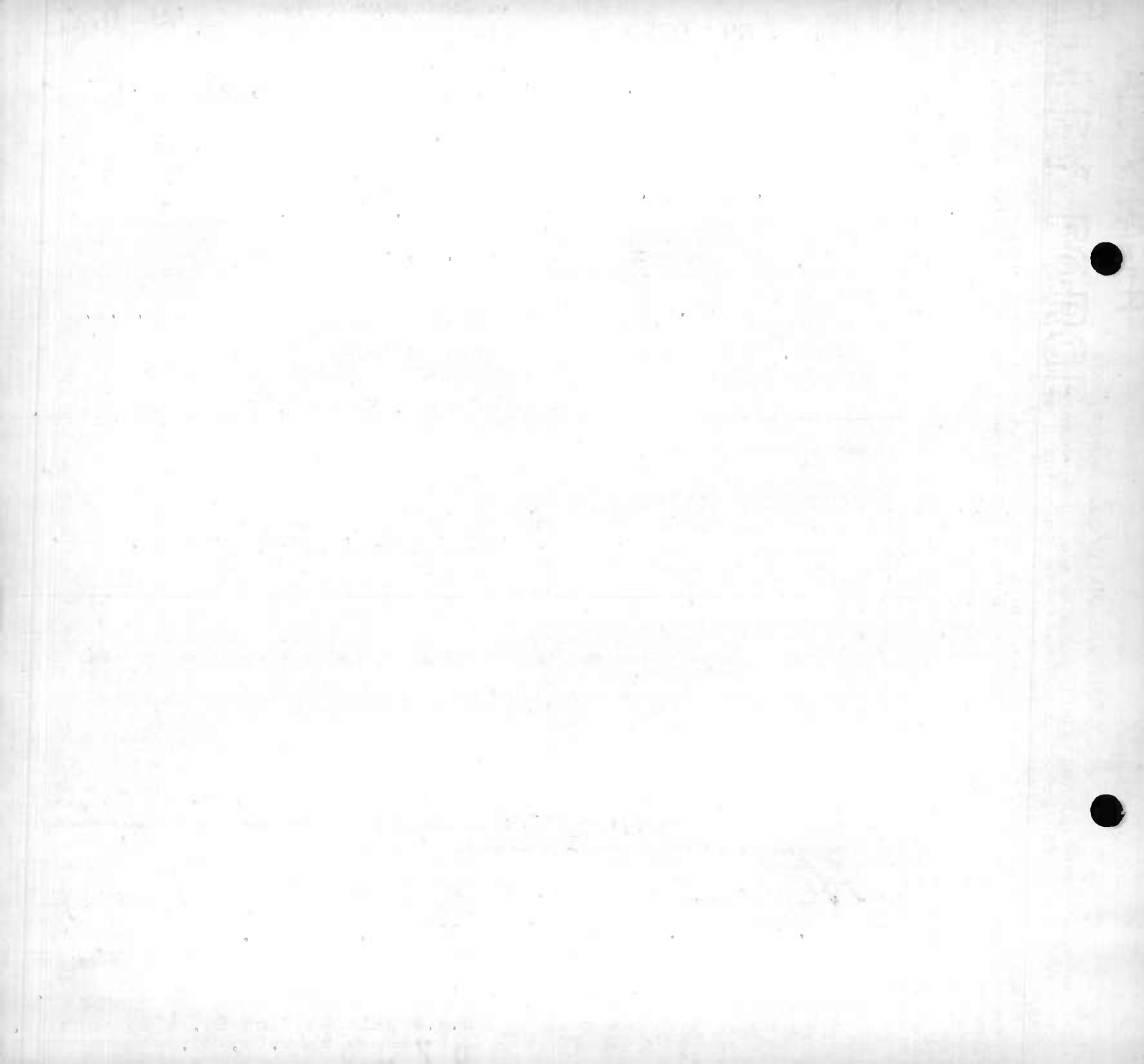
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
69 0727 CERTIFICATE OF DEATH

REG. NO.

69 0727

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Eva S. Hubbard		January 18, 1969 11-4 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 00 506 W. 27th St.				A. STATE Md. B. COUNTY 12-07	
				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 507 W. 27th St.	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 26, 1889	9. AGE (In years last birthday) 79
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Weaver		Mt. Vernon Mills		Maryland	
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY?	
Washington A. Hamilton				U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		218-18-8468		John H. Hubbard, 8212 Watersedge Rd.	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of bladder 2 yr.					
(B) DUE TO, OR AS A CONSEQUENCE OF: Generalized metastasis 1 yr.					
(C)					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (the hospital) attended the deceased from Jan. 1967 to 1-18-1969, that (I) last saw the deceased alive on 1/18-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Dr. Robert F. Chenowith				1/20/69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. Robert F. Chenowith				1114 St. Paul St.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		1/22/69		Baltimore	
				Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 21 1969		Robert E. Jenkins		H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>69 0728</b>	
BIRTH NO. <b>69 0728</b>		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <b>January 20, 1969</b> <span style="float: right;"><b>7 A M.</b></span>	
1. NAME OF DECEASED (Type or Print) <b>MARGARET SOMMERS</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <b>207 S. Ellwood Avenue</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1-02</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>207 S. Ellwood Avenue</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>March 26, 1908</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Counter Girl</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Cafeteria</b>	9. AGE (In years lost birthday) <b>60</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
11. BIRTHPLACE (State or foreign country) <b>Cregsville, Virginia</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>224-01-0772</b>	
17. INFORMANT <b>James Henry Sommers</b>		ADDRESS <b>207 S. Ellwood Ave.</b>	
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>Gradual failure of heart</b> DUE TO <b>2 metastatic</b> (B) <b>Heart failure - mellitus</b> DUE TO (C)	
INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>6</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>July 19 18</b> to <b>July 19 69</b> that (I) (we) last saw the deceased alive on <b>July 19 69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>J. H. Goodman</b>		23B. DATE SIGNED <b>1/21/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Julius H. Goodman M.D.</b>		23D. ADDRESS <b>9 S Highland Ave</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-23-1969</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Carmel</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1969</b>		25B. NAME OF REGISTRAR <b>Rebecca E. Fisher</b>	
25C. FUNERAL DIRECTOR <b>Lilly &amp; Zeiler Inc.</b>		ADDRESS <b>1901-07 Eastern Ave.</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0729

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 69 0729

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MISS MARY MARGARET QUINN</b>		2. DATE AND HOUR OF DEATH <b>Jan 20 / 1969</b> <b>12:45 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>24-02</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>BON SECOURS HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>406 E. CLEMENT ST.</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/30/99</b>	9. AGE (In years last birthday) <b>69</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>JOHN QUINN</b>		14. MOTHER'S MAIDEN NAME <b>SARAH COONEY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-03-4953</b>		17. INFORMANT ADDRESS <b>Miss Marcella Quinn, 406 E. Clement St.</b>	
18. <b>156.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>ca of gall bladder</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>with metastasis to liver and bile duct - obstructive jaundice</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>due to above - mentioned diag.</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>generalized hemorrhage</b>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>11/13/69</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>obstructive jaundice</b>	20A. AUTOPSY? (Yes or No) <b>None</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE OLD INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>1-8</b> <b>1969</b> to <b>Jan 20</b> <b>1969</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>Jan 20</b> <b>1969</b> and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>Mehdi Sarkarati M.D.</b>				23B. DATE SIGNED <b>Jan 20 / 1969</b>	
23C. PHYSICIAN'S NAME (Type) <b>Mehdi Sarkarati M.D.</b>				23D. ADDRESS <b>Bon Secours Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1-23-69</b>	24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>4300 Old Frederick Rd., Balto Md</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1969</b>	25B. NAME OF REGISTRAR <b>Robert E. Sarkarati</b>	25C. FUNERAL DIRECTOR ADDRESS <b>Flynn &amp; Fleming, 1422 Light St.</b>			

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11-1-11

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		DEATH NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
JENNIE BELLE Demby		01-16-69 3:20 P.M.		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
JOHNS HOPKINS HOSPITAL		JOPPA		YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
F		N		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Domestic		Household		12-15-1895	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)	
HENRY TURNER		CLARA BROADWAY		75	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
no		212-22-0902-A		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE		2 weeks	
ANTECEDENT CAUSES		(B) Diabetic vascular disease		10 years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
None				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
None		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (the hospital) attended the deceased from 1-11-69 to 1-16-69 that (I) (we) last saw the deceased alive on 1-16-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (didn't) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Ronald G Michels MD				1-16-69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
RONALD G Michels MD				Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		Jan. 20, 1969		John Wesley Methodist Cemetery Magnolia Harford Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 21 1969		Robert E. Farley		Howard K. McComas & Son, Abingdon, Md.	

Chapter 1: Introduction to the study of the history of the United States

Chapter 2: The American Revolution  
Chapter 3: The American Civil War  
Chapter 4: The American Industrial Revolution  
Chapter 5: The American West  
Chapter 6: The American South  
Chapter 7: The American Midwest  
Chapter 8: The American Northeast  
Chapter 9: The American Northwest  
Chapter 10: The American Southwest  
Chapter 11: The American Southeast  
Chapter 12: The American Central  
Chapter 13: The American West  
Chapter 14: The American South  
Chapter 15: The American Midwest  
Chapter 16: The American Northeast  
Chapter 17: The American Northwest  
Chapter 18: The American Southwest  
Chapter 19: The American Southeast  
Chapter 20: The American Central

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 0731

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

SHERMAN T. POTTEIGER

2. DATE  
OF  
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

January 20, 1969 2:05 A. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

SOUTH BALTIMORE GENERAL (DOA)

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

January 20, 1969 2:05 A. M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

24-09

6. SEX

Male

7. RACE

White

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

Jan. 30, 1908

10. AGE (In years  
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

437 E. Fort Ave.

11. BIRTHPLACE (State or foreign country)

Pa.

12. CITIZEN OF  
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Aaron Potteiger

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Mechanic

14B. KIND OF BUSINESS OR INDUSTRY

Sheet Metal

15. MOTHER'S MAIDEN NAME

Bertha Unknown

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Mr. Wm. A. Potteiger 211 Bertram Circle

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A.

DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A.

EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

22D.

TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL

SIGNATURE

EXAMINER'S

NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/20/69

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1 22 69

24C. NAME OF CEMETERY or CREMATORY

Cedar Hill

24D. LOCATION (City, town, or county)

Brooklyn, A. A. Co. Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Mc Gully

130 E. Fort Ave.

JAN 21 1969

R. N. Kornblum

VIA AIR MAIL

WEEKLY

MAGAZINE

1550 83



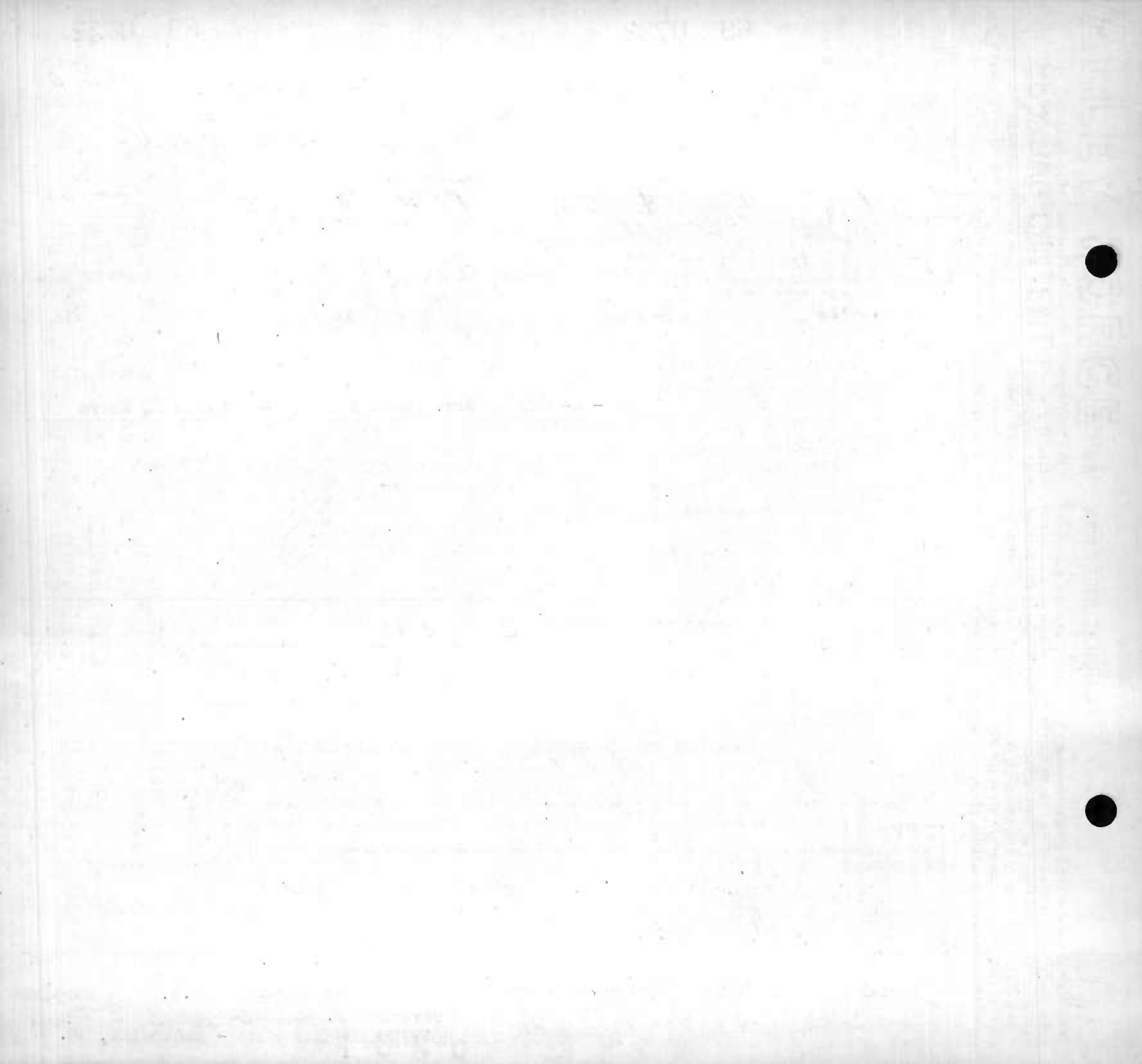
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 69 0732 CERTIFICATE OF DEATH

REG. NO. 69 0732

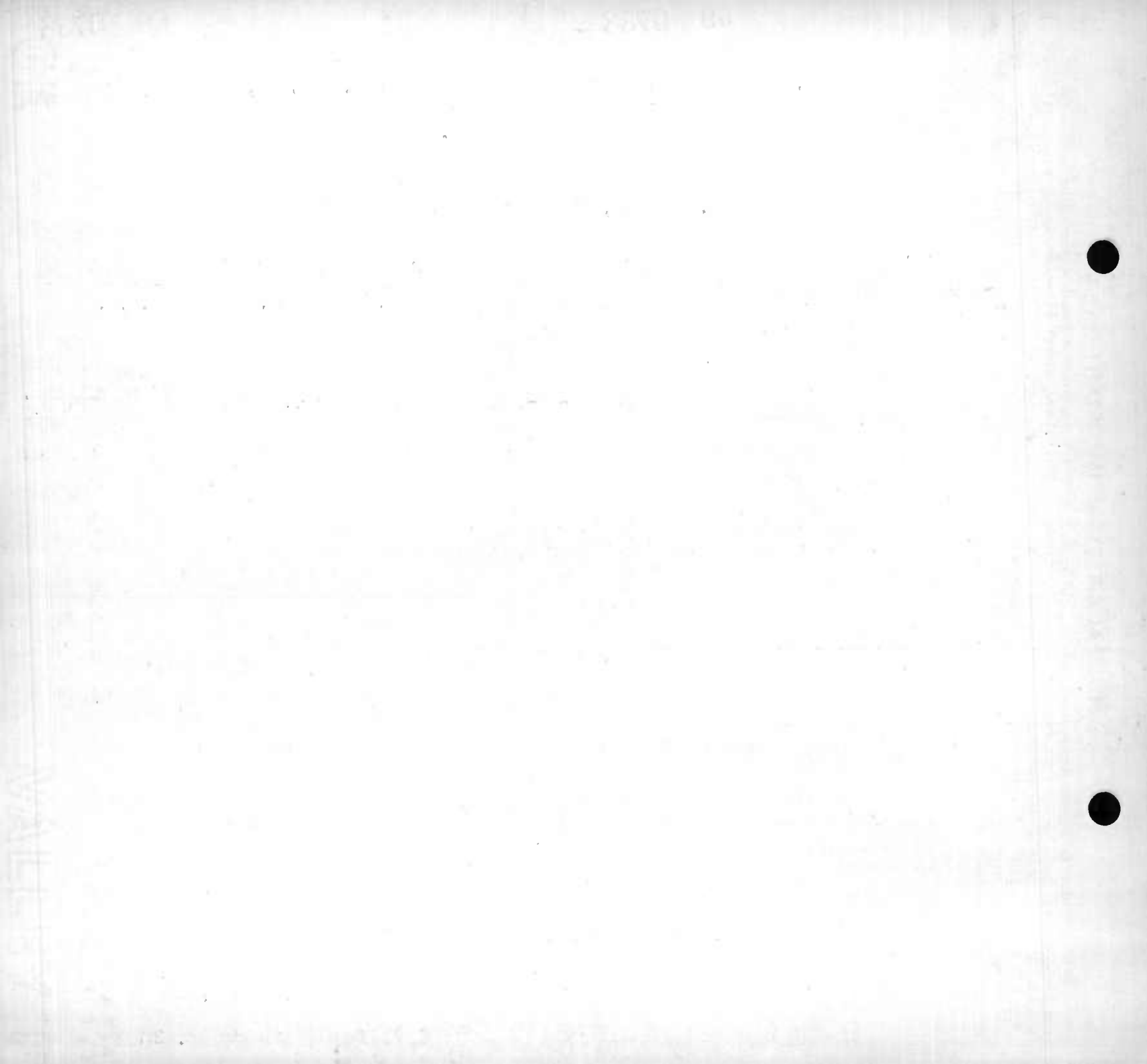
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>McKnew, MARYA</i>		2. DATE AND HOUR OF DEATH <i>1-16-69 6:45 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Anne Arundel</i> 52-00	
FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore General Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Gambrills</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>F</i> 6. RACE <i>A</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2-14-89</i> 9. AGE (in years last birthday) <i>79</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Winfield Murray</i>		14. MOTHER'S MAIDEN NAME <i>Louise Lowman</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>214-54-0822</i>		17. INFORMANT ADDRESS <i>Mrs. Madelyn Downs - same as #4 above</i>	
18. <i>440.91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <i>Congestive Heart Failure</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8 years</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerosis</i>		<i>8 years</i>	
(C) _____		_____		_____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<i>Cystitis</i>		<i>day</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11/9/1969</i> to <i>6:45 pm 1/16/1969</i> , that (I) (we) last saw the deceased alive on <i>1/16/1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Rifat Abouy</i> DEGREE				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>Rifat Abouy MD</i> DEGREE				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/20/69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Glen Haven Cemetery</i>	
24D. LOCATION (City, town, or county) <i>Glen Burnie</i>		(State) <i>A.A. Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 21 1969</i>	
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Beverly E. Hopping</i> ADDRESS <i>HOPPING FUNERAL HOME - Annapolis, Md.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
69 0733 CERTIFICATE OF DEATH					REG. NO. 69 0733				
1. NAME OF DECEASED (Type or Print) <b>Mrs. Renetta Thersa Yienger</b>					2. DATE AND HOUR OF DEATH <b>Sat. Jan. 18, 1969</b> <b>2:30</b> M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 House in the Pines Belvedere Belvedere Ave. Pinlico, Maryland</b>					C. CITY OR TOWN <b>Pikesville Md</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
					E. STREET AND NUMBER <b>3547 Milford Mill Road</b>				
5. SEX <b>F.M.</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 1, 1987</b>	9. AGE (In years last birthday) <b>81</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Partner in Linatype</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Compisition Business</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore. County Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>? Bauer</b>					14. MOTHER'S MAIDEN NAME <b>Deilia ?</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>202 220-01-5372</b>		17. INFORMANT ADDRESS <b>Antone Yienger 3547 Milford Mill Rd. Pikesville Maryland</b>				
18. CAUSE OF DEATH <b>412.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Congestive Heart Failure</b> (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>				
					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Hypertensive CV Disease</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>years</b>				
					(C) _____				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>10/31/61</b> 19 to <b>present</b> 19, that (I) <del>(*)</del> last saw the deceased alive on <b>12/1/68</b> 19 and that in (my) <del>(or)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(do not)</del> view the body after death.									
23A. SIGNATURE <b>Ronald R. Berger, M.D.</b>					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>1/18/69</b>		
23C. PHYSICIAN'S NAME (Type) <b>Ronald R. Berger, M.D.</b>					23D. ADDRESS <b>8501 Liberty Road, Baltimore 21207</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/21/69</b>		24C. NAME of CEMETERY or CREMATORY <b>New Cathedral Cem/</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taberna</b>		25C. FUNERAL DIRECTOR <b>Loring Byers</b>		ADDRESS <b>8728 Liberty Rd. 21133</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

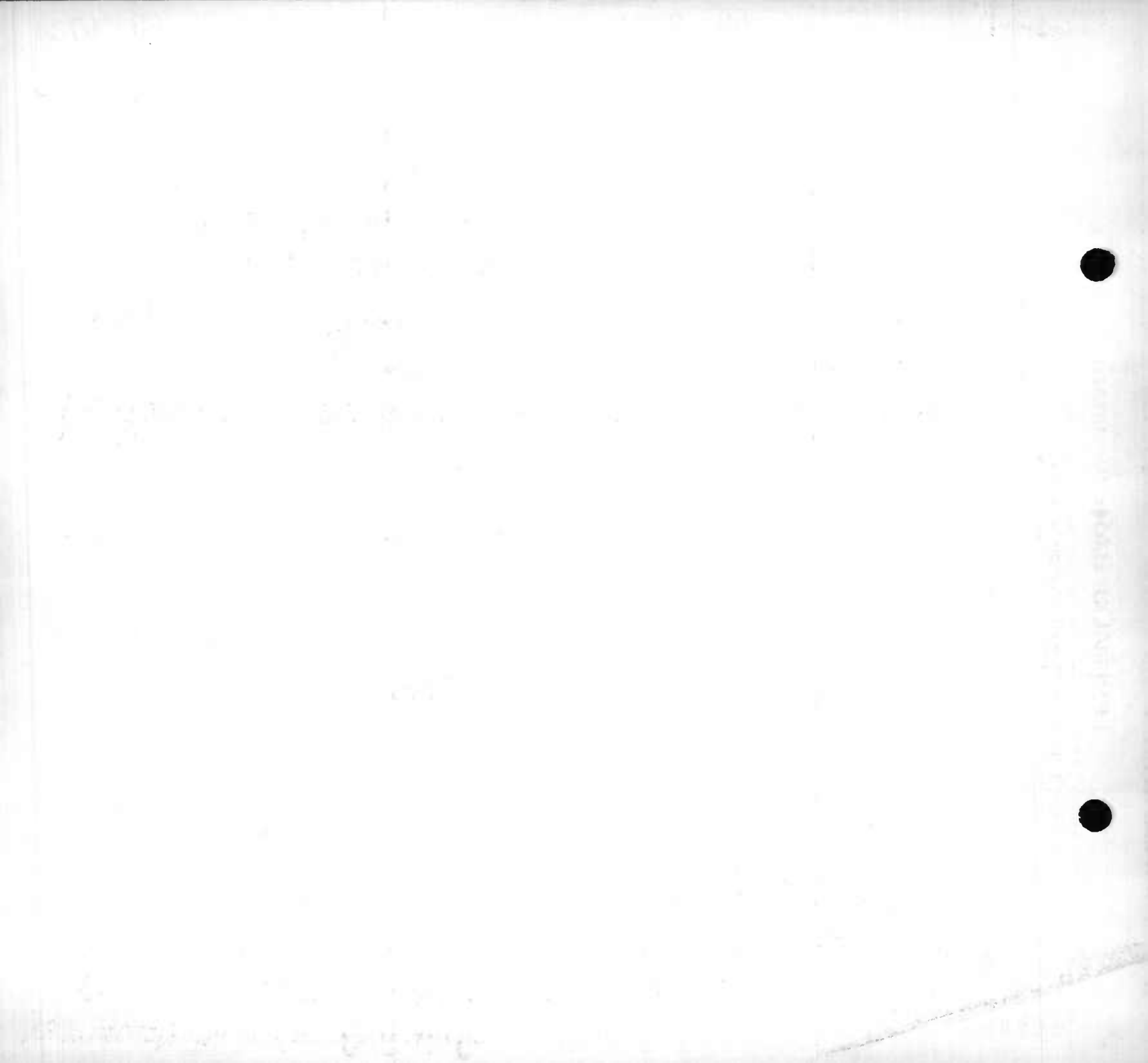
69 0734

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

69 0734

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Samuel Leiser</u>		2. DATE AND HOUR OF DEATH <u>Jan 19, 1969 11:30 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>28-31</u>		C. CITY OR TOWN <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 SINAI HOSP</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>		6. RACE <u>Cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>Nov 11, 1877</u>	
13. FATHER'S NAME <u>Louis</u>		14. MOTHER'S MAIDEN NAME <u>Helene</u>		9. AGE (in years last birthday) <u>91</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-18-3667A</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
17. INFORMANT <u>Mrs Betty Leiser</u>		ADDRESS <u>4110 Fallstaff Rd</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
18. <u>4124 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Bronchopneumonia</u> (B) <u>ASCVD</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>Years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Chronic Renal Disease</u>				<u>Years</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notably medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>Jan 18</u> 19 <u>69</u> to <u>Jan 19</u> 19 <u>69</u> that (1) (we) lost saw the deceased alive on <u>Jan 19</u> 19 <u>69</u> and that (1) (my) (one) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Joseph E. Mark MD</u>		23B. DATE SIGNED <u>Jan 19 1969</u>		23C. PHYSICIAN'S NAME (Type) <u>Joseph E. Mark MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/20/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Chesapeake Avenue Chapel</u>	
24D. LOCATION (City, town, or county) <u>Randallstown</u>		24E. LOCATION (State) <u>Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1969</u>	
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Sylvan S. Taylor &amp; Son, Inc</u>		ADDRESS <u>9610 Randallstown Rd</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0735 BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

69 0735

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

FLORENCE M. FISHER

2. DATE AND HOUR OF DEATH

JAN 19 1969 1 50 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

THE UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

3540 ROLAND AVENUE

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

01-30-85

9. AGE (In years last birthday)

83

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

AMERICA

13. FATHER'S NAME

EDWARD COLBURN

14. MOTHER'S MAIDEN NAME

MARY MIXTER

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

220-48-9574

17. INFORMANT

THE CHART

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

CACHEXIA

(B) CHRONIC ARTERIOSCLEROTIC CARDIO-

DUE TO, OR AS A CONSEQUENCE OF:

VASCULAR DISEASE

(C) INTERNAL MALIGNANCY

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

ABOUT

ONE MONTH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from DECEMBER 29 1968 to JANUARY 19 1969, that (I) (we) last saw the deceased alive on JANUARY 19 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Kun Kee Ryu MD

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

JANUARY 19 1969

23C. PHYSICIAN'S NAME (Type)

KUN KEE RYU MD

23D. ADDRESS

THE UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1/22/69

24C. NAME OF CEMETERY or CREMATORY

Parkwood Cemetery

24D. LOCATION

Baltimore,

(City, town, or county)

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 21 1969

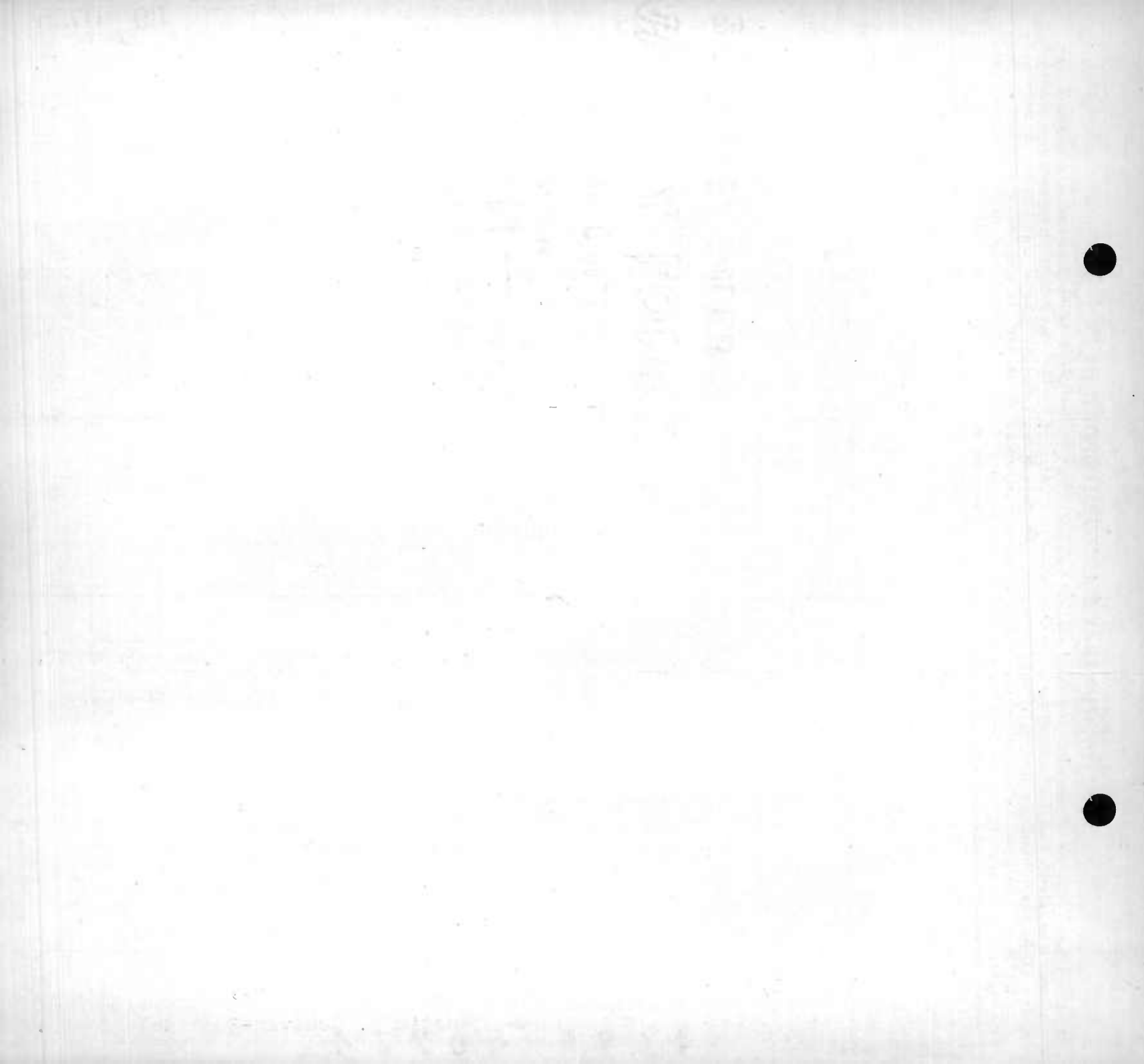
25B. NAME OF REGISTRAR

Robert E. Fisher

25C. FUNERAL DIRECTOR

Austin E. Donovan-3818 Roland Ave.

ADDRESS





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause of death was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>E-520</u> 69 0736				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>69</u> 0736	
1. NAME OF DECEASED (Type or Print) <u>Leora K Ewing</u>				2. DATE AND HOUR OF DEATH <u>1/18/69</u> <u>11:30</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>33 THE JOHNS HOPKINS HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>TALBOT</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 THE JOHNS HOPKINS HOSPITAL</u>				C. CITY OR TOWN <u>EASTON</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <u>R.F.D. # 4 BOX 58</u>							
5. SEX <u>F</u> FEMALE <u>W</u> WHITE	6. RACE <u>W</u> WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-26-16</u>	9. AGE (In years last birthday) <u>52</u>	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWORK</u>		11. BIRTHPLACE (State or foreign country) <u>NEW YORK STATE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>DAVID KIDD</u>				14. MOTHER'S MAIDEN NAME <u>KATHERINE REYNOLDS</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>49-76-7172</u>		17. INFORMANT <u>H. CLARK EWING</u>		ADDRESS <u>EASTON</u>	
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>metastatic carcinoma of lung.</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>metastatic carcinoma of lung.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>2 Jan 1969</u> to <u>18 Jan 1969</u> that (1) (we) last saw the deceased alive on <u>Jan 18 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>D. B. Case, M.D.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1/29/</u>	
23C. PHYSICIAN'S NAME (Type) <u>David B. Case, M.D.</u>				23D. ADDRESS <u>The Johns Hopkins Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>1-21-69</u>		24B. DATE <u>1-21-69</u>		24C. NAME of CEMETERY or CREMATORY <u>SPRING HILL</u>		24D. LOCATION (City, town, or county) (State) <u>EASTON TALBOT MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1969</u>		25B. NAME OF REGISTRAR <u>R. B. 29, Talbot</u>		25C. FUNERAL DIRECTOR <u>R. B. 29, Talbot</u>		ADDRESS <u>EASTON, MD</u>	

the first of the summer of 1907

100

from 15 to 20

Buttane, N.D.

David B. Cox, N.D. The 2nd of June, 1907

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0737 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 69 0737

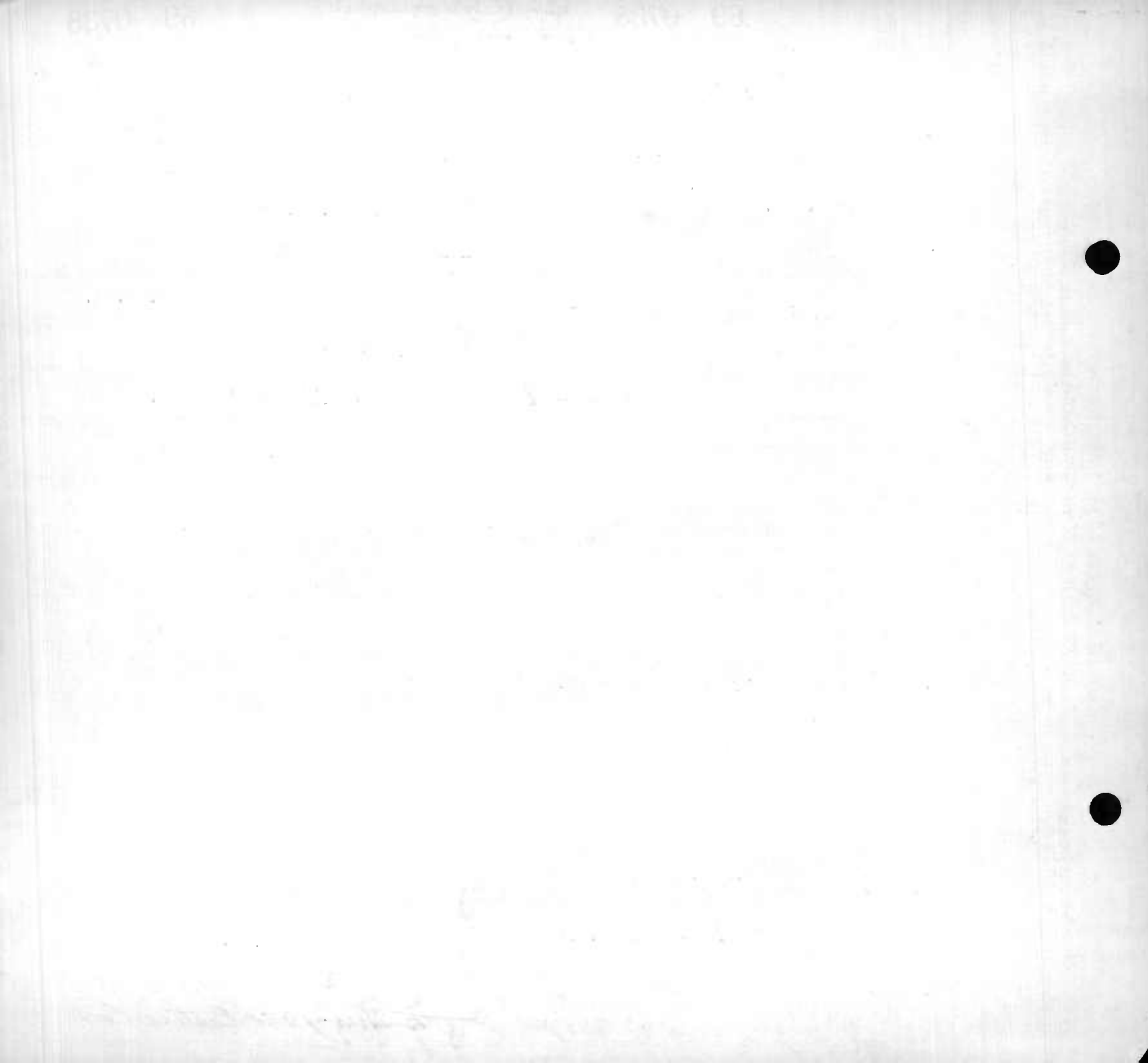
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Ruth Jennings</i>		2. DATE AND HOUR OF DEATH <i>January 18, 1969</i>		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>24-01</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>00 1301 Andres</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>1301 Andre ST</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/15/24</i>	9. AGE (In years lost birthday) <i>44</i>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Nurse</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Doctor's Hospital</i>		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>	
13. FATHER'S NAME <i>Charles J. Taylor</i>				14. MOTHER'S MAIDEN NAME <i>Ruth O'Neal</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>198-18-1385</i>		17. INFORMANT <i>Kathy Tanner</i>		ADDRESS <i>1325 Andre ST</i>	
18. <i>7-10-9 I</i>		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		<i>Coronary Occlusion</i>				<i>Immediate</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary artery disease</i>				<i>1 year</i>	
(B) _____		(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 15</i> 19 <i>68</i> to <i>Jan 18</i> 19 <i>69</i> that (I) (we) last saw the deceased alive on <i>Jan 10</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Harry Deibel M.D.</i>				23B. DATE SIGNED <i>1/20/69</i>		23C. PHYSICIAN'S NAME (Type) <i>HARRY DEIBEL M.D.</i>	
				23D. ADDRESS <i>1226 S HANOVER STREET</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/22/69</i>		24C. NAME of CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>Charles L. Stevens</i>		25C. FUNERAL DIRECTOR <i>Charles L. Stevens Funeral Home, Inc</i>		ADDRESS <i>0 75316 East Fort Avenue</i>	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

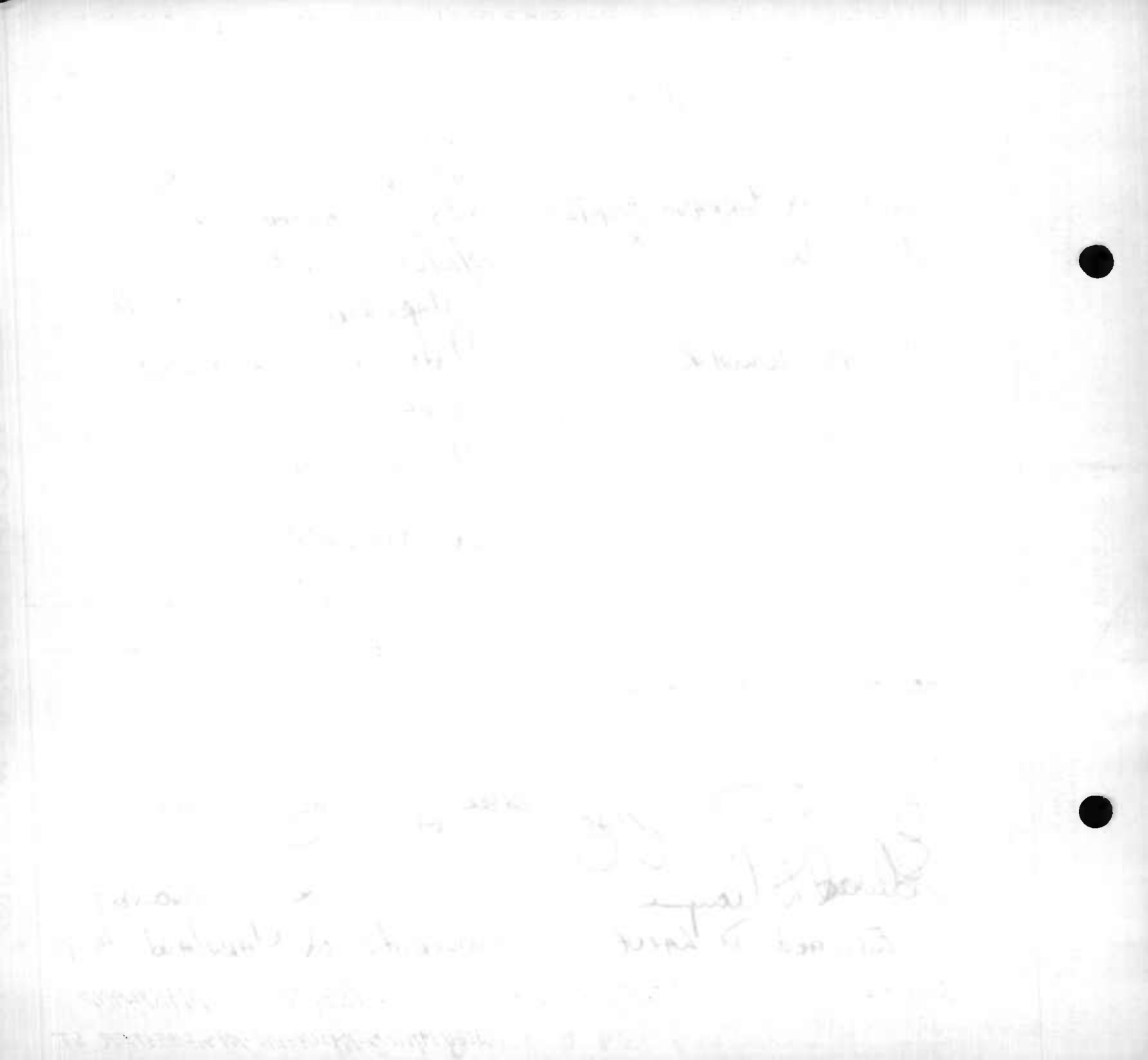
A-216		69 0738		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 0738	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>MARVIN ASBURY</b>				2. DATE AND HOUR OF DEATH <b>1-18-69 6:30 P M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>3-01</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVE.</b> <b>BALTO. MD. 21224</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>1413 GOUGH ST. 21231</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-1-02</b>	9. AGE (In years last birthday) <b>66</b>	If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard - Balto City (Poplar St)</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>SMITH Asbury</b>			
14. MOTHER'S MAIDEN NAME <b>ALSTON, MOLLIE</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>403-03-1766</b>				17. INFORMANT ADDRESS <b>BCH RECORDS: 4940 EASTERN AVE. 21224</b>			
18. <b>011.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>PSEUDOMONAS PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>PULMONARY TUBERCULOSIS</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <b>12-2-68</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>TBC ABSCESS @ LUNG</b> 20A. AUTOPSY? (Yes or No) <b>NO</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			
21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11-14</b> 19 <b>68</b> to <b>1-18</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>1-18</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>William E. Powers, M.D.</b>				23B. DATE SIGNED <b>1-18-69</b>			
23C. PHYSICIAN'S NAME (Type) <b>WILLIAM E. POWERS, M.D.</b>				23D. ADDRESS <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVE. 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/22/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Balto. Nat. Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>5501 Fred. Rd. Bal. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 22 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Salome</b>		25C. FUNERAL DIRECTOR <b>T. Fisher - 1930 Eastern Chas.</b>		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 0739		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 0739	
1. NAME OF DECEASED (Type or Print) <u>TOMALSKI, James F.</u>		2. DATE AND HOUR OF DEATH <u>21 JAN 1969 1 545 A M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University of Maryland Hospital</u>		A. STATE <u>MARYLAND</u>		B. COUNTY <u>Baltimore</u>	
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>823 S. Decker St.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/10/01</u>	9. AGE (in years lost birthday) <u>67</u>	10. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>Thomas Tomalski</u>		14. MOTHER'S MAIDEN NAME <u>Madeline Twandowicz</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>246-05-5363</u>		17. INFORMANT <u>CHART.</u> ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Metastatic CA</u>			
ANTECEDENT CAUSES		(B) <u>CA of Prostate</u> DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>28 Dec 1968</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>PARAPLEGIA</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>28 Dec 1968</u> to <u>21 JAN 1969</u> that (I) (we) last saw the deceased alive on <u>21 Jan 1969</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Edward D. Kayne</u>		23B. DATE SIGNED <u>21 Jan 69</u>			
23C. PHYSICIAN'S NAME (Type) <u>Edward D. Kayne</u>		23D. ADDRESS <u>University of Maryland Hosp</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY <u>HOLY ROSARY CEMETERY BALTO</u>	
24D. LOCATION (City, town, or county) <u>MARYLAND</u>		24E. STATE <u>MARYLAND</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 22 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>JOHN M. WAGNER</u>	
ADDRESS <u>401 E. CHESTER ST.</u>					





**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-652		69 0740		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 0740	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>ISADOR HERINGMAN</b>			
2. DATE AND HOUR OF DEATH <b>JAN 19/69 11:20 P.M.</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 BELVEDERE NURSING HOME</b> <b>2525 W. BELVEDERE AVENUE</b>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>27-20</b>				C. CITY OR TOWN <b>BLATIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <b>3502 SEVEN MILE LANE #21208</b> <del>XXXXGREENSPRINGAVENUE</del>							
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUGUST 1890</b>		9. AGE (In years last birthday) <b>78</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>EXECUTIVE</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ABRAHAM HERINGMAN</b>				14. MOTHER'S MAIDEN NAME <b>VENTA ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-05-6866A</b>		17. INFORMANT <b>MRS. RUTH KATZ, 6227 GREENSPRING AVE. #21209</b>			
18. <b>412.317230.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>1) Arteriosclerosis Heart disease 10 yrs</b> <b>2) Diabetes mellitus 20 yrs?</b> <b>3) Coronary heart infection</b> <b>4) Arteriosclerosis</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Pulmonary Edema</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Arteriosclerosis Heart disease 10 yrs</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Arteriosclerosis 20 yrs?</b> <b>1) Arteriosclerosis Heart infection</b> <b>2) Diabetes mellitus</b> <b>3) Coronary heart infection</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 14 1969</b> to <b>Jan 19 1969</b> , that (I) <del>was</del> last saw the deceased alive on <b>6 pm 1/14 1969</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did) <del>(did not)</del> view the body after death.							
23A. SIGNATURE <b>Jonas Cohen M.D.</b>				23B. DATE SIGNED <b>1/19/69</b>		23C. PHYSICIAN'S NAME (Type) <b>JONAS COHEN</b>	
23D. ADDRESS <b>6702 Park Heights Ave. Balt. Md 21215</b>				23E. DATE REC'D BY HEALTH DEPT. <b>JAN 22 1969</b>		23F. NAME OF REGISTRAR <b>22208. J. Cohen</b>	
23G. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>				23H. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>		23I. DATE <b>1-21-69</b>	
23J. NAME OF CEMETERY or CREMATORY <b>CHIZUK AMUNO (ARLINGTON)</b>				23K. REMOVAL (Specify) <b>BURIAL</b>		23L. DATE <b>1-21-69</b>	

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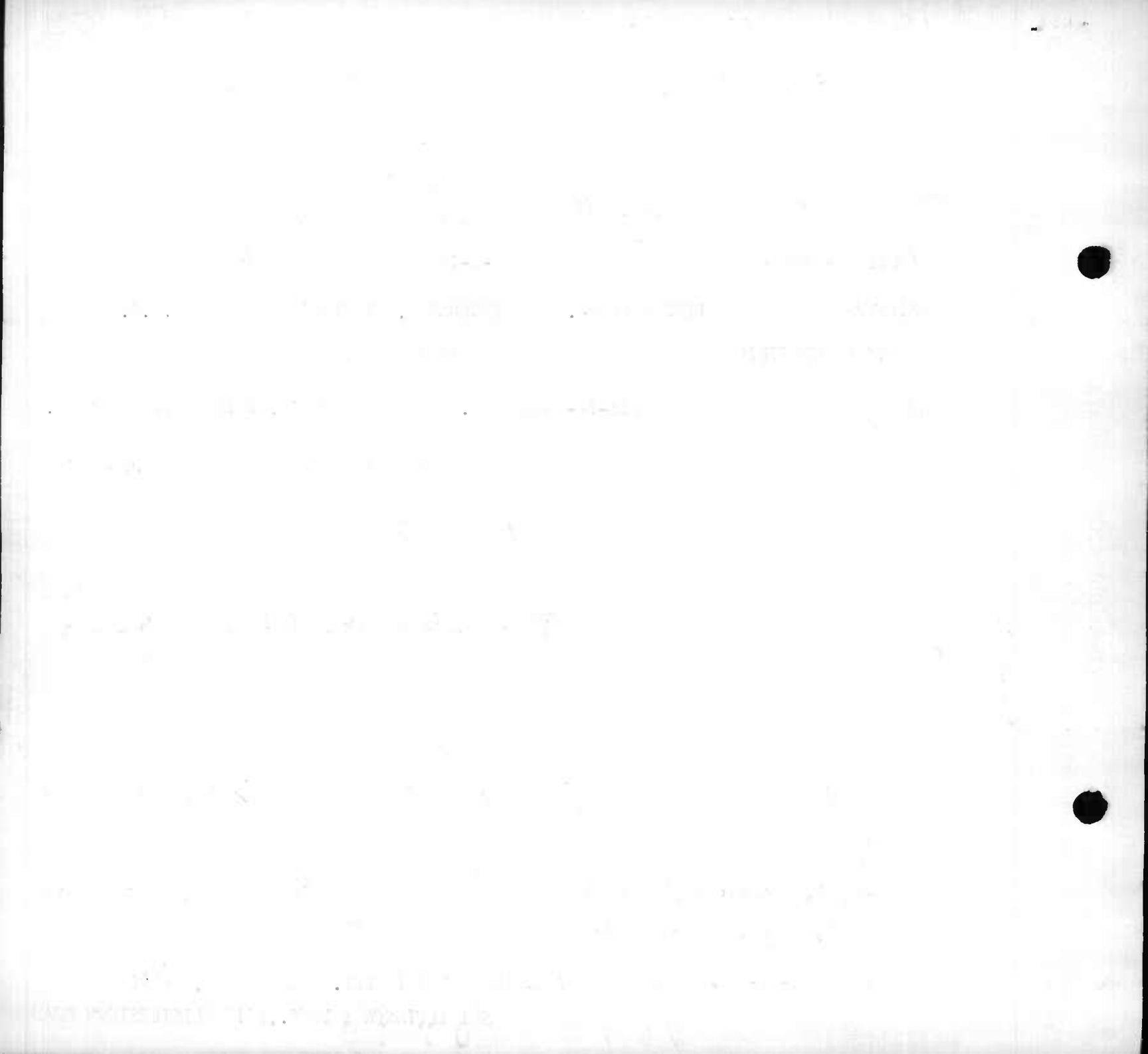
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

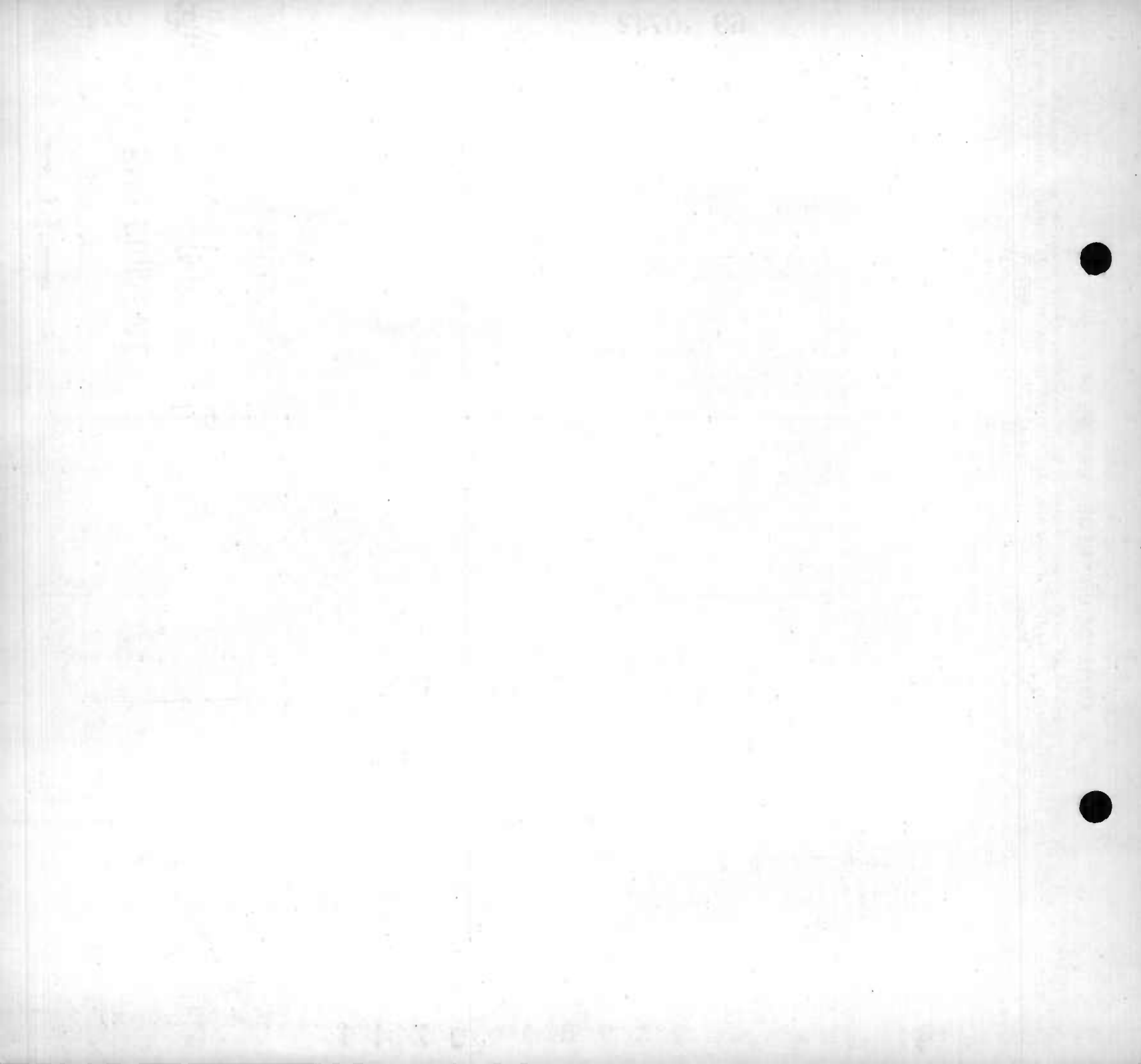
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">69 0741</span>	
69 0741				CERTIFICATE OF DEATH	
BIRTH NO. <span style="float: right;">14-152</span>		1. NAME OF DECEASED (Type or Print) <b>ABRAHAM Abe Hoppenstein</b>		2. DATE AND HOUR OF DEATH <b>Jan 20, 1969 2:20 AM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b>		53-00	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hospital of Baltimore</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>1013 SCOTTS HILL DRIVE</b>		8. DATE OF BIRTH <b>3-7-1912</b>		9. AGE (In years last birthday) <b>56</b>	
5. SEX <b>MALE</b>	6. RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11. BIRTHPLACE (State or foreign country) <b>LYNCHBURG, VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HESS SHOE CO.</b>			
13. FATHER'S NAME <b>HARRIS HOPPENSTEIN</b>		14. MOTHER'S MAIDEN NAME <b>HANNAH ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-10-3384</b>		17. INFORMANT <b>MRS. REBA HOPPENSTEIN, 1013 SCOTTS HILL DR. #8</b>	
18. <b>412.41-250.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Arrhythmia</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ASCVD</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Diabetes Mellitus</b>				<b>Years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 5 1969</b> to <b>Jan 20 1969</b> that (I) (we) lost saw the deceased alive on <b>Jan 20 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Joseph E. Mark MD</b>		DEGREE		23B. DATE SIGNED <b>Jan 20, 1969</b>	
23C. PHYSICIAN'S NAME (Type) <b>Joseph E. Mark</b>		DEGREE		23D. ADDRESS <b>SINAI HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-21-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>BNAI ISRAEL (MISHKON ISRAEL SECT.)</b>	
24D. LOCATION <b>BALTIMORE, MARYLAND</b>		24E. NAME OF REGISTRAR <b>SOL LEVINSON &amp; BROS.</b>		24F. FUNERAL DIRECTOR ADDRESS <b>6010 REISTERSTOWN ROAD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 22 1969</b>		25B. NAME OF REGISTRAR <b>SOL LEVINSON &amp; BROS.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>6010 REISTERSTOWN ROAD</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

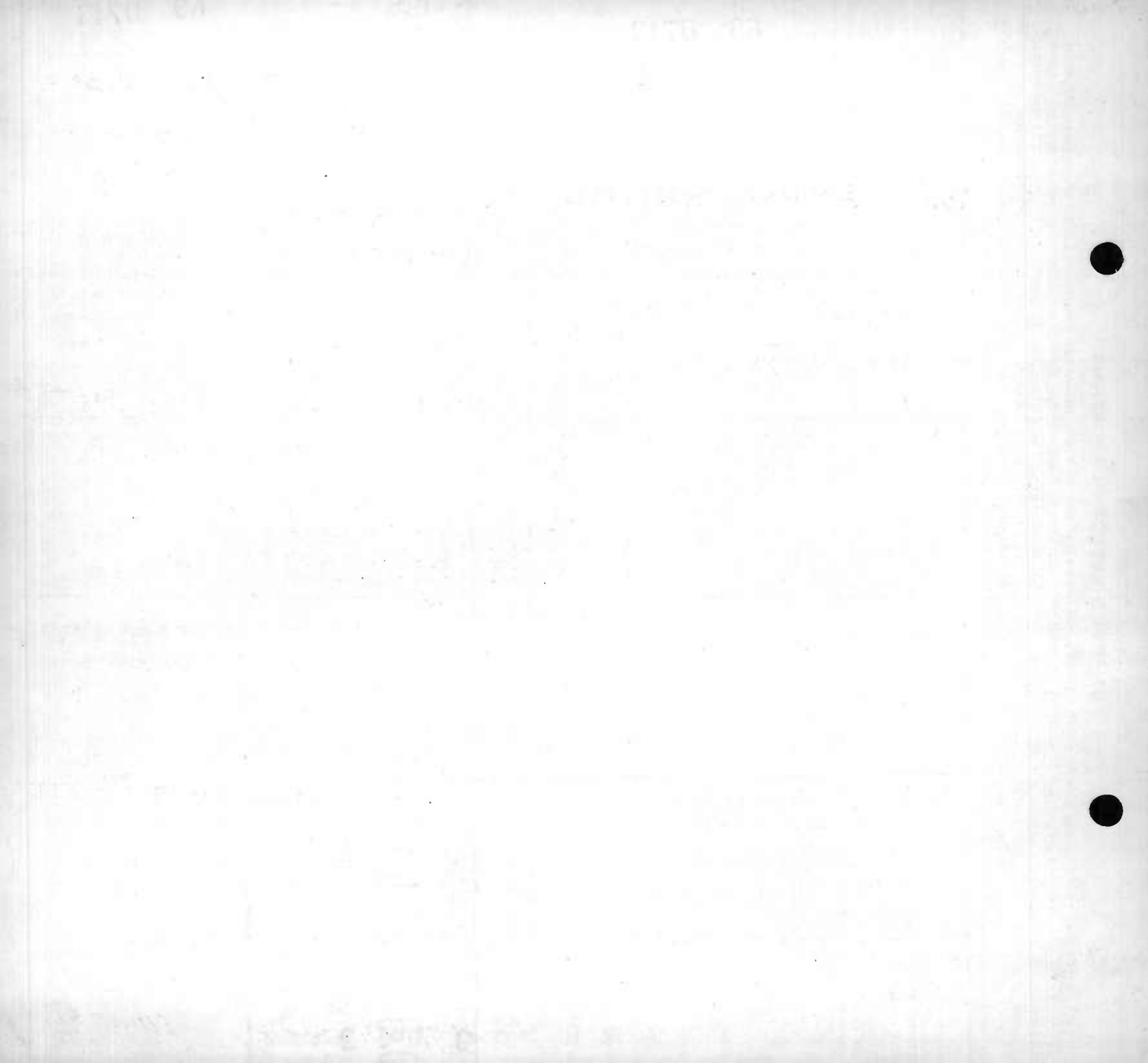
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
BIRTH NO. 62-17837		69 0742		69 0742	
1. NAME OF DECEASED (Type or Print) <i>Stinchcomb Master Frank J.</i>		2. DATE AND HOUR OF DEATH <i>1-19-69</i>   <i>6:00 A. M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bon Secours Hosp.</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Baltimore, Md.</i>		5. STATE <i>Md.</i>	
6. CITY OR TOWN <i>Baltimore</i>		7. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8. STREET AND NUMBER <i>1125 Ward St.</i>	
9. SEX <i>Male</i>	10. RACE <i>White</i>	11. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12. DATE OF BIRTH <i>9-16-68</i>	13. AGE (In years last birthday) <i>4</i>	14. Under 1 Yr. Months: Days: Hours: Min. <i>4</i>
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>child</i>		16. KIND OF BUSINESS OR INDUSTRY <i>none</i>		17. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>	
18. FATHER'S NAME <i>Edward Stinchcomb</i>		19. MOTHER'S MAIDEN NAME <i>Mildred Brown</i>		20. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
21. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <input checked="" type="checkbox"/>		22. SOCIAL SECURITY NO. <i>-</i>		23. INFORMANT <i>Mr Edward Stinchcomb</i>	
24. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Segmental Phlegm of the Transverse Colon Intussusception, at Cecal Edema</i>		25. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <i>Segmental Phlegm of the Transverse Colon Intussusception, at Cecal Edema</i>		26. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>since birth</i>	
27. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		28. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		29. II	
30. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1-16</i> 19 <i>69</i> to <i>1-19</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>1-19</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Josephine I. Brindley</i>		23B. DATE SIGNED <i>1-21-69</i>		23C. PHYSICIAN'S NAME (Type) <i>Bon Secours Hosp.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/22/69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Cedar Hill Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Pitohie Hwy Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 22 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Edwards</i>	
25C. FUNERAL DIRECTOR <i>John J. Edwards</i>		25D. ADDRESS <i>23rd St.</i>		25E. ADDRESS <i>23rd St.</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 0743				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 0743			
1. NAME OF DECEASED (Type or Print) William Carter				2. DATE AND HOUR OF DEATH 1-17-69 2:30 P. M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND- 19-03 B. COUNTY							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BON SECOURS HOSPITAL				C. CITY OR TOWN BALTIMORE				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER 1805 W. PRATT ST. 1							
5. SEX M		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-25-04		9. AGE (In years lost birthday) 64		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10B. KIND OF BUSINESS OR INDUSTRY PAPER HANGER				11. BIRTHPLACE (State or foreign country) Va		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Ned Carter				14. MOTHER'S MAIDEN NAME Julia Mills							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. ?		17. INFORMANT MARGIE CARTER		ADDRESS 1805 W PRATT ST BALTO.			
18. 492X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH Right heart failure (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic emphysema Myocardial infarct. (B) DUE TO, OR AS A CONSEQUENCE OF: St. post pneumonia only (C) <del>Chronic emphysema</del> 12 YEARS.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks years Mos.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). RT Lower lobe bronchopneumonia days											
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) N		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Y					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 1-9-69 to 1-17-69, that (I) (we) lost saw the deceased olive on 1-17-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Shaweng Ongkasuwan M.D. DEGREE								Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-17-69	
23C. PHYSICIAN'S NAME (Type) SHAWENG ONGKASUWAN M.D. DEGREE				23D. ADDRESS BON SECOURS HOSPITAL							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-21-69		24C. NAME OF CEMETERY or CREMATORY MT Hebron Cem.				24D. LOCATION (City, town, or county) (State) Winchester VA.			
25A. DATE REC'D BY HEALTH DEPT. JAN 22 1969				25B. NAME OF REGISTRAR G. E. Taylor				25C. FUNERAL DIRECTOR H. H. Slack			
								ADDRESS ELICOTT CITY MD			





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H-635

69 0744 BALTIMORE CITY HEALTH DEPARTMENT

69 0744

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>A. CHARLES HARDING JR</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>January 20, 1969</b>		Hour <b>12:05 P.M.</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 626 S. Monroe Street (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>January 20, 1969</b>		Hour <b>12:05 P.M.</b>
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>20-03</b>				
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>
9. DATE OF BIRTH <b>11-20-1900</b>		10. AGE (In years last birthday) <b>68</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		E. STREET AND NUMBER <b>626 S. Monroe Street</b>
13. FATHER'S NAME <b>Charles A. Harding</b>		14. MOTHER'S MAIDEN NAME <b>Alma Tobias</b>		
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Driver</b>		14B. KIND OF BUSINESS OR INDUSTRY		15. ADDRESS <b>21223 Mrs. Eleanor Harding, 626 S. Monroe Street</b>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.		18. INFORMANT <b>Mrs. Eleanor Harding, 626 S. Monroe Street</b>
19. CAUSE OF DEATH <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Pulmonary Emphysema</b>				
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>no</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1/20/69</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-23-1969</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		24E. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. ADDRESS

JAN 22 1969

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X

X

WALLEY

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

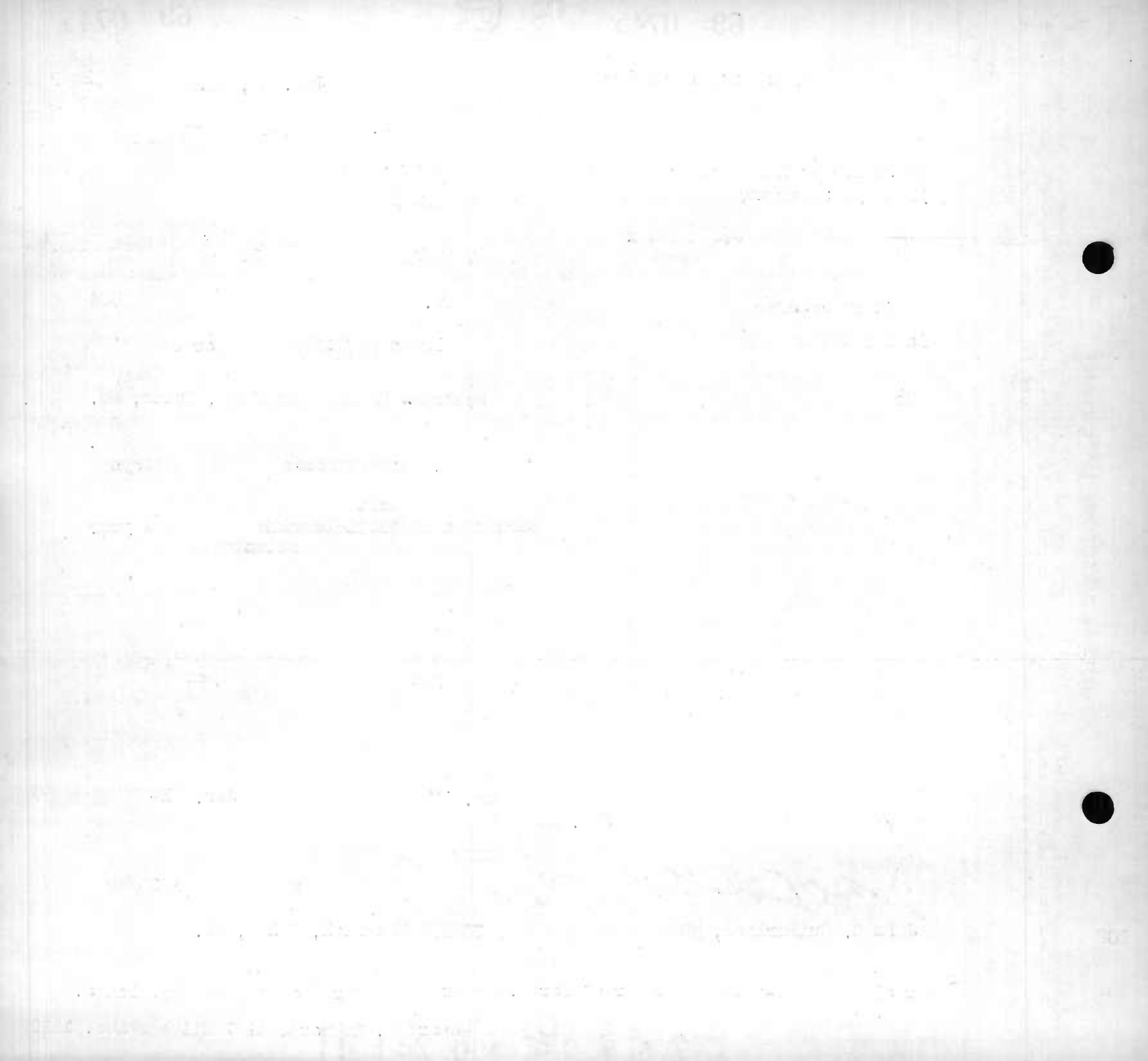
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69 0745

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 69 0745

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Wayne Melvin Pfeffer</b>		2. DATE AND HOUR OF DEATH <b>Jan. 19, 1969</b> <b>11 P</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>US Public Health Service Hospital 3100 Wyman Parkway</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Pa.</b> B. COUNTY <b>Schuylkill</b> <b>V-35</b> C. CITY OR TOWN <b>Clarksummit</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>RFD 2</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/27/41</b>	9. AGE (In years last birthday) <b>27</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Store manager</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pa.</b>	
13. FATHER'S NAME <b>Paul Pfeffer</b>				14. MOTHER'S MAIDEN NAME <b>Irene <del>Barrett</del> Sharer</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT ADDRESS <b>Records- US PHS Hospital, Balto, Md.</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>186X I</b> <b>Bronchopneumonia</b> left <b>Carcinoma of/testicle with metastases</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>1 year</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 17</b> <b>1968</b> to <b>Jan. 19</b> <b>1969</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Jan. 19</b> <b>1969</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour end from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death.					
23A. SIGNATURE <b>John C. Sutherland, MD</b> DEGREE				23B. DATE SIGNED <b>1/20/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>John C. Sutherland, MD</b> DEGREE				23D. ADDRESS <b>US PHS Hospital, Balto, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-24-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Memorial Park Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Bethlehem Township Northhampton County, Penna.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 22 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Jankins</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>	



THOMAS LEO MARTIN, SR.

CERTIFICATE OF DEATH

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		THOMAS L. MARTIN, Sr.		JAN. 19, 1969 3 <sup>29</sup> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				Maryland	
5. SEX				6. RACE	
Male				White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				8. DATE OF BIRTH	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				1893	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				9. AGE (In years lost birthday)	
CONDUCTOR				4-19-1893 75	
10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)	
RAILROAD				Maryland	
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY?	
Phillip				U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
NO				717-07-8365	
17. INFORMANT				ADDRESS	
Records: BCH-4940 Eastern Avenue 21224					
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PNEUMONIA					
(B) DUE TO, OR AS A CONSEQUENCE OF: CVA					
(C) DUE TO, OR AS A CONSEQUENCE OF: HASCVD					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
COPD					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Dec. 18 19 68 to JAN. 19 19 69, that (I) (we) last saw the deceased alive on JAN. 18 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Joseph Kaplan				JAN. 19, 1969	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Joseph Kaplan				4940 Eastern Avenue, Baltimore, Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		1/22/1969		OAK LAWN	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 22 1969		Robert E. Ferguson		WALTER BROOKS BRADLEY, DUNDALK, MD.	

FUNERAL DIRECTOR: IMPORTANT

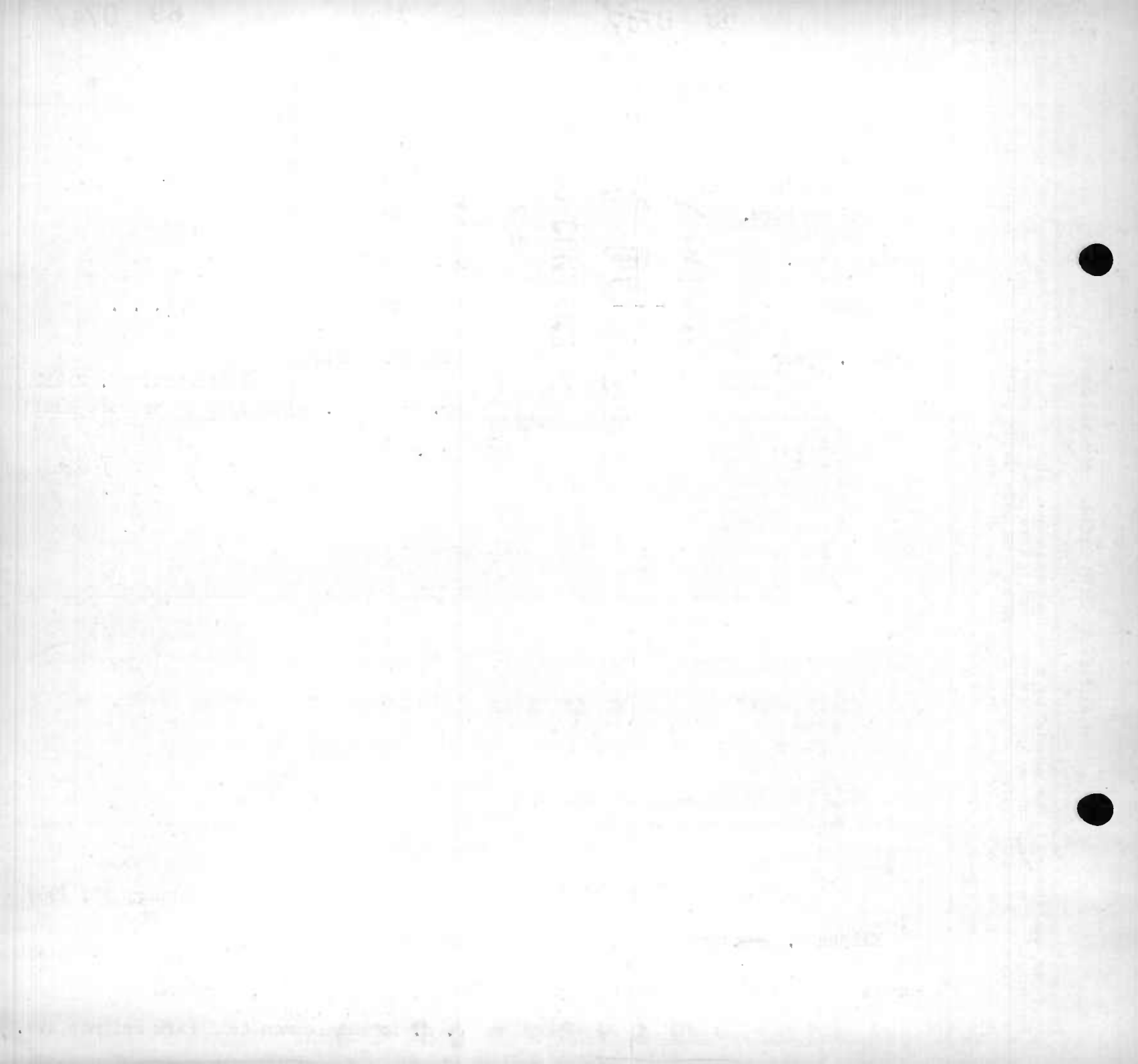
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

11-01-71

1/SS/1

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 0747	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Ella Spear MARCH			13 JAN 69		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
Garrison Nursing Home 2803 Garrison Blvd.			Maryland		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			3317 Woodland Avenue		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
Female	Cauc.	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	24 JUN 1886	82	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Homemaker			Maryland		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Louis C. Spear			Catherine Wright		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
NO					
17. INFORMANT			Baltimore, Md. 21212		
			Mr. Howard C. March 1338 Cedarcroft Road		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
412.4 I			ASCVD & Gangrene of Rt Arm		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Elijah B. Saunders				January 15, 1969	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Elijah B. Saunders				3414 Duvall Avenue	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1/17/69		Druid Ridge Cemetery	
				Pikesville, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 22 1969		Robert G. Saunders		E. J. Lowell	
ADDRESS					
4611 Park Heights Ave.					





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69 0748 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 0748  
REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>EDITH B. FINCH</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>January 21, 1969</b> Hour <b>2:00 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>00 503 S. Rappolla (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 21, 1969 7:20 A.M.</b>	
6. SEX <b>female</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE <b>white</b>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Dec. 23, 1909</b>		10. AGE (In years last birthday) <b>59</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>216-50-0169</b>	
15. MOTHER'S MAIDEN NAME <b>Theresa Neede</b>		18. INFORMANT (Husband) ADDRESS <b>Mr. Thomas S. Finch, 503 Rappolla St. Balto. Md.</b>	
19. <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b> M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1/21/69</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/24/69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 22 1969</b>		25B. NAME OF REGISTRAR <b>Regina E. Fairbairn</b>	
25C. FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>		ADDRESS	

2700 88

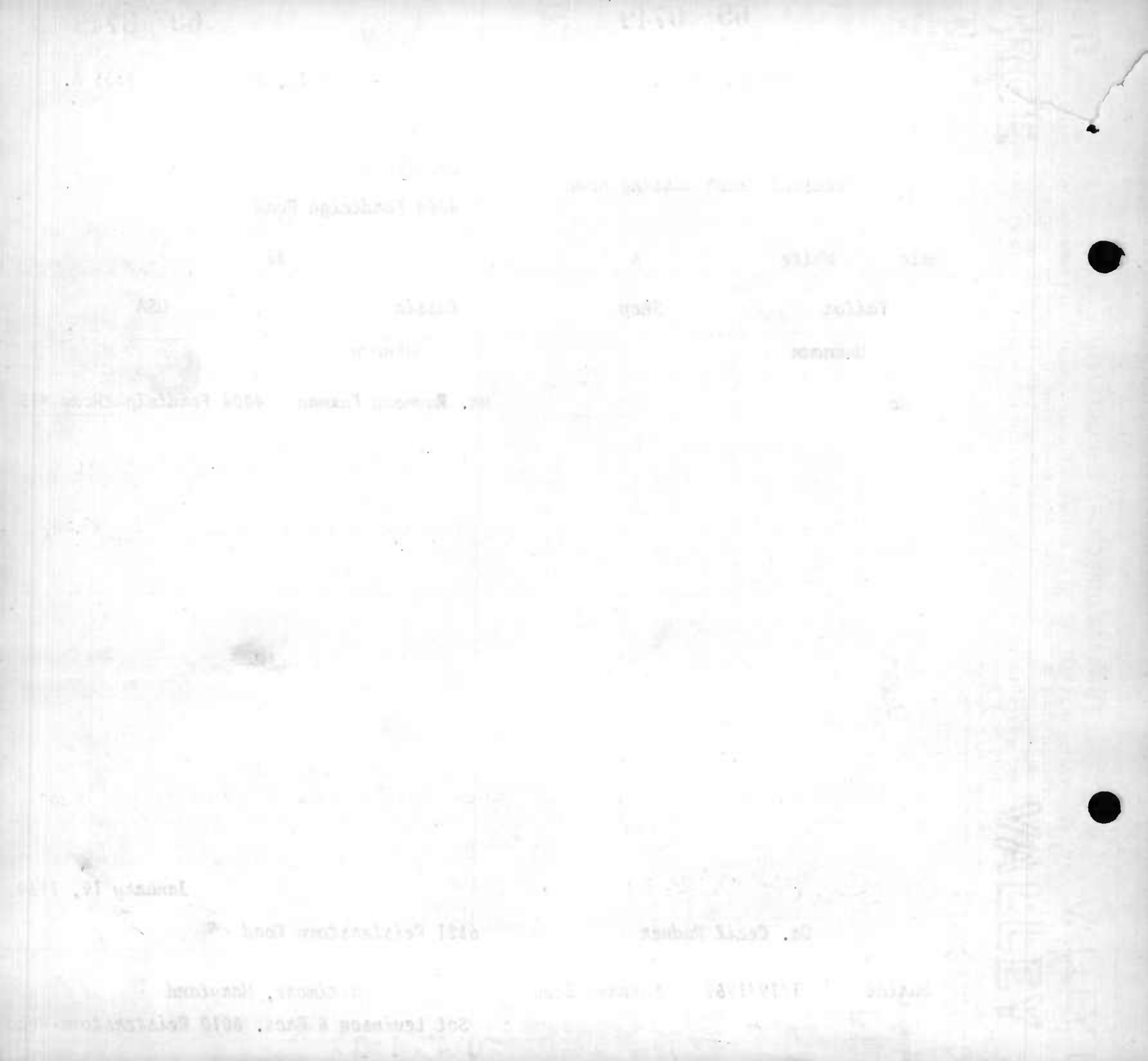
1951

VALLEY OF THE GIANTS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

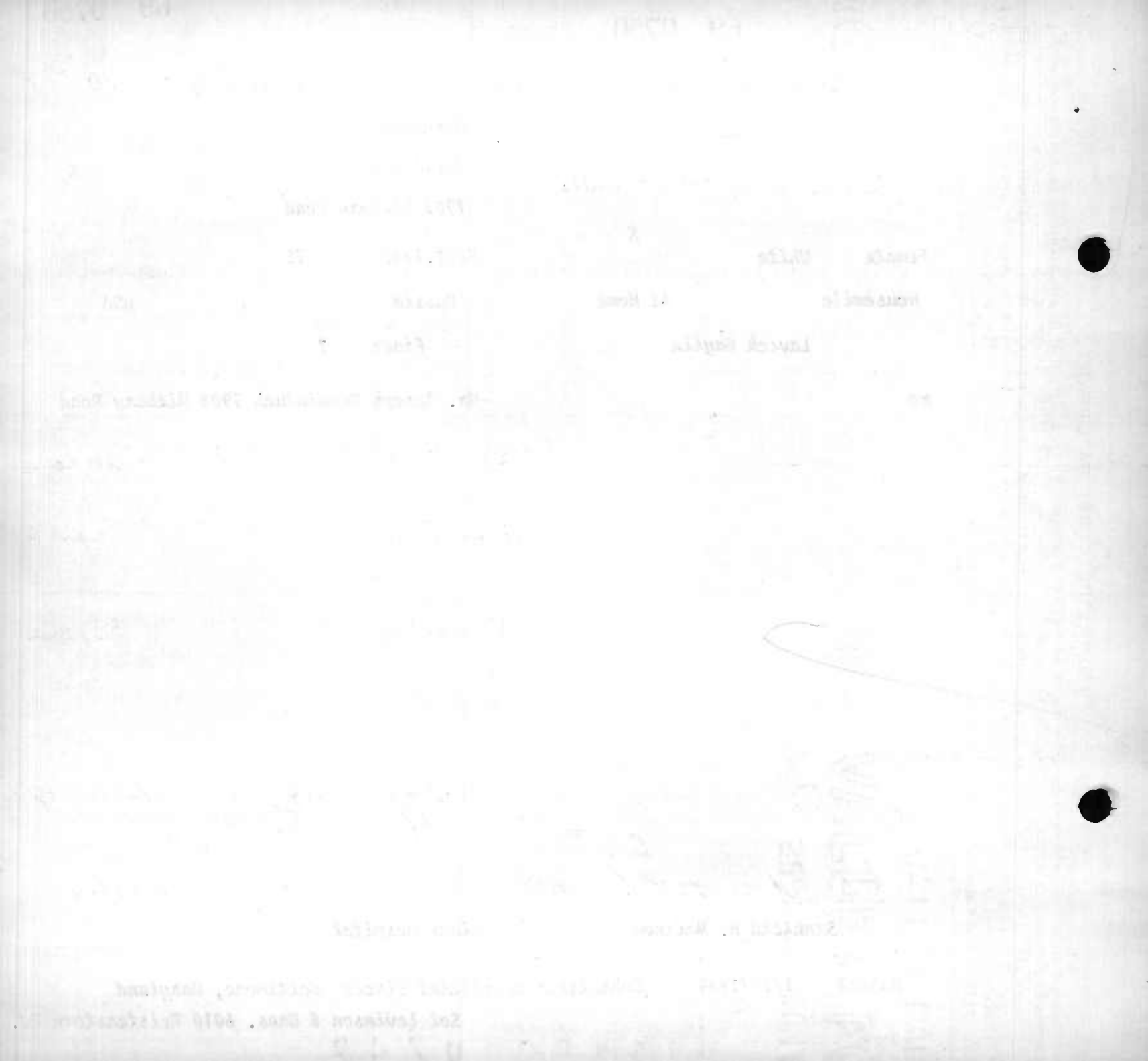
69 0749 BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 0749	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MORRIS FUXMAN		JANUARY 18, 1969 9:35 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION  90 Pleasant Manor Nursing Home			Maryland C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4004 Fordleigh Road		
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 86	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10B. KIND OF BUSINESS OR INDUSTRY Shop	11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mr. Raymond Fuxman 4004 Fordleigh Road #15		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastatic Carcinoma 1 year (B) Pulmonary Carcinoma 2 years (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from December 1966 to January 1969, that (I) (we) last saw the deceased alive on January 18, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Cecil Rudner			23B. DATE SIGNED January 19, 1969		23C. PHYSICIAN'S NAME (Type) Dr. Cecil Rudner
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 1/19/1969		24C. NAME OF CEMETERY or CREMATORY Shaarei Zion
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			25A. DATE REC'D BY HEALTH DEPT. JAN 22 1969		
25B. NAME OF REGISTRAR Robert E. Johnson			25C. FUNERAL DIRECTOR ADDRESS Sol Levinson & Bros. 6010 Reisterstown Road		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
69 0750				69 0750	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <b>Gussie Schointuch</b>			2. DATE AND HOUR OF DEATH <b>1/18/69 10<sup>00</sup> P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balto. CO</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 Sinai Hospital of Balto</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>7908 Milbury Road</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 1896</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Lavick Baylin</b>			14. MOTHER'S MAIDEN NAME <b>Frade ?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Mr. Joseph Schointuch 7908 Milbury Road</b>		
18. <b>45601-2509</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebrovascular Accident</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 hours</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Hypertension</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Diabetes</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>33 years</b>		
19A. DATE OF OPERATION <b>1/18/69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>1/18/69</b> to <b>1/18/69</b> , that (1) (we) last saw the deceased alive on <b>1/18/69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Stanford H. Malinow MD</b>				23B. DATE SIGNED <b>1/18/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Stanford H. Malinow</b>				23D. ADDRESS <b>Sinai Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/19/1969</b>		24C. NAME of CEMETERY or CREMATORY <b>Bobroisker Beneficial Circle Baltimore, Maryland</b>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 22 1969</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Sol Levinson &amp; Bros. 6010 Reisterstown Rd.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Y-100 69 0751				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 0751	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				ROSA R. VOFFE		JANUARY 17, 1969 8:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				MARYLAND		27-20	
6508 PARK HEIGHTS AVENUE, APT. A				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				6508 PARK HEIGHTS AVENUE, APT. A			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
FEMALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		88			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE		AT HOME		LITHUANIA		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
JOSHUA FALK		GITTEL ?					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO		NO		JUDGE JOSEPH ALLEN, 7121 PK. HIGHTS. AVE., APT. 207			
18. 44421 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Bronchopneumonia		2 days	
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Mesenteric Thrombosis		1 week	
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				Cerebral sclerosis		9 mos.	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
O				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from Feb. 19 65 to Jan. 17 1969, that (I) (we) lost saw the deceased alive on Jan. 17 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Louis E. Wice				1/18/69			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
LOUIS E. WICE				920 ST. PAUL STREET			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		1-19-1969		BALTIMORE HEBREW		BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
JAN 22 1969		Robert E. Sankara		SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			

2508 TAIN WENTON AVENUE, WY. A

LEWIS WHITE

AT HOME

LEWIS WHITE

LEWIS WHITE

LEWIS WHITE

LEWIS WHITE, 2508 TAIN WENTON AVENUE, WY. A

LEWIS WHITE

LEWIS WHITE

LEWIS WHITE

LEWIS WHITE

LEWIS WHITE



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0752		BALTIMORE CITY HEALTH DEPARTMENT		X		69 0752	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		REG. NO.	
W-622		WARSHAWSKY, Sylvia		January 19, 1969 8:40 A.M.		23-00	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence, before admission)		5. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				6. CITY OR TOWN		7. INSIDE CITY LIMITS?	
33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205				BALTIMORE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX				6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
male				WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH				9. AGE (In years last birthday)		10. Under 1 Yr. Months Days	
8-9-10				58		11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
PROPRIETOR				GAS STATION		BALTIMORE, MARYLAND	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
MEYER WARSHAWSKY				IDA ?		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
NO				216-28-3237		MRS. LILLIAN WARSHAWSKY, 8136 SCOTTS LEVEL RD.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4/10/9 I				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		CARDIO-PULMONARY FAILURE	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(B) DUE TO, OR AS A CONSEQUENCE OF:		MYOCARDIAL INFARCTION	
ANTECEDENT CAUSES				(C) DUE TO, OR AS A CONSEQUENCE OF:		ARTERIO-SCLEROTIC DISEASE	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
1/15/69				DECEASED ARTERIAL INSUFFICIENCY		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from 1/9/69 19 to 1/19 1969 that (1) (we) last saw the deceased alive on 1/19 1969 and that in (we) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
Vernon T. ToLo, M.D.				1/19/69		VERNON T. TOLO M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL				1-20-69		SHAAREI ZION	
25A. DATE RECEIVED BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 22 1969				Robert E. Jarbo		SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	
24D. LOCATION (City, town, or county) (State)				24E. ADDRESS		24F. ADDRESS	
ROSEDALE, MARYLAND				THE JOHNS HOPKINS HOSPITAL		SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	

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# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT									
69 0753 CERTIFICATE OF DEATH					REG. NO. 69 0753				
BIRTH NO. <span style="font-size: 2em;">D-250</span>									
1. NAME OF DECEASED (Type or Print) <b>SADIE DUCHON</b>					2. DATE AND HOUR OF DEATH <b>JANUARY 20, 1969 3:40 A.M.</b>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b>				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>JEWISH CONVELESANT HOME</b> <span style="font-size: 1.5em;">70</span>					C. CITY OR TOWN <b>RANDALLSTOWN</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				
					E. STREET AND NUMBER <b>3916 SHENTON ROAD</b>				
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-18-1886</b>	9. AGE (In years last birthday) <b>82</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>BEN EPSTEIN</b>					14. MOTHER'S MAIDEN NAME <b>LENA PINDRUS</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>MILLER DEUTSCH MEMORIAL CHAPEL, 27570 CHAGRIN BLVD., CLEVELAND, OHIO 44122</b>				
					ADDRESS				
18. <span style="font-size: 1.5em;">43691</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CNA c comm</b>									
(B) <b>Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF:									
(C) _____									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION <b>○</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>January 17, 1969</b> to <b>January 20, 1969</b> , that (I) (we) last saw the deceased alive on <b>Jan 20 19 69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Nathan Needee</b>					23B. DATE SIGNED <b>Jan 20, 1969</b>				
23C. PHYSICIAN'S NAME (Type) <b>NATHAN NEEDEE</b>					23D. ADDRESS <b>6506 PARK HEIGHTS AVENUE</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-22-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>RIDGE RD. CEMETERY #2</b>		24D. LOCATION (City, town, or county) (State) <b>BROOKLYN HEIGHTS, OHIO</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 22 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairburn</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>		ADDRESS			

THE UNIVERSITY OF CHICAGO

CHICAGO, ILLINOIS

U.S.A.

CHICAGO

AT HOME

HOUSE-1-E

THE UNIVERSITY

CHICAGO, ILLINOIS  
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 5-265				BALTIMORE CITY HEALTH DEPARTMENT				69 0754				REG. NO. 69 0754			
1. NAME OF DECEASED (Type or Print) ISIDORE SUGARMAN								2. DATE AND HOUR OF DEATH 1-18-69 1:40 PM							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD								4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205								C. CITY OR TOWN BALTIMORE				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
								E. STREET AND NUMBER 3409 LUDGATE ROAD							
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH [REDACTED]		9. AGE (In years last birthday) 73		10. Under 1 Yr. Months		11. Under 24 Hrs. Days		12. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor				10B. KIND OF BUSINESS OR INDUSTRY Self Employed				11. BIRTHPLACE (State or foreign country) Poland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME HENRY SUGARMAN								14. MOTHER'S MAIDEN NAME ESTHER ?							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 216-32-9464				17. INFORMANT Mrs. Frieda Sugarman 3409 Ludgate Road #15							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 450X1x250.9 CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>myocardial infarction</u> (B) <u>pulmonary</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ~ 5 days - 3 hrs ~ 1 week								19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II maturity onset Diabetes Mellitus 18 mos.							
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) Yes				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 1/13 19 69 to 1/18 19 69 that (I) (we) last saw the deceased alive on 1/16 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.															
23A. SIGNATURE David T. Jackson								23B. DATE SIGNED 1/18/69				23C. PHYSICIAN'S NAME (Type) DAVID T. JACKSON M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial								24B. DATE 1/19/1969				24C. NAME OF CEMETERY OR CREMATORY Hebrew Young Mens			
24D. LOCATION Baltimore, Maryland								24E. DATE REC'D BY HEALTH DEPT. JAN 22 1969							
24F. NAME OF REGISTRAR Robert E. Farber								24G. FUNERAL DIRECTOR Sol Levinson & Bros. 6010 Reisterstown Road							

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-351		69 0755		BALTIMORE CITY HEALTH DEPARTMENT		X		69 0755		
BIRTH NO.		CERTIFICATE OF DEATH				REG. NO.				
1. NAME OF DECEASED (Type or Print) <u>Paula Steinberg</u>					2. DATE AND HOUR OF DEATH <u>Jan 19, 1969 12:02 A.M.</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Sinai Hospital of Baltimore</u>					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u> <u>53-00</u>					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Sinai Hospital of Baltimore</u>					C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
					E. STREET AND NUMBER <u>4516 MARYKNOLL ROAD</u>					
5. SEX <u>FEMALE</u>	6. RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/14/93</u>	9. AGE (in years last birthday) <u>75</u>	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>ADOLPH BAER</u>					14. MOTHER'S MAIDEN NAME <u>THERESA SPIER</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>MR. KURT M. STEINBERG, 4516 MARYKNOLL RD.</u>					
18. <u>395X-1-E8841</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Asystole</u> <u>Myocardial Infarction</u> <u>Rheumatic Heart Disease</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u> <u>Years</u> <u>Years</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Lumbar Compression Fracture</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 Month</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nally medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>Home</u>			21C. WHERE DID INJURY OCCUR? <u>4516 Maryknoll Rd.</u>		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) <u>12/22/68</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>			21F. HOW DID INJURY OCCUR? <u>Fell off couch</u>					
22. I certify that (H) (this hospital) attended the deceased from <u>Dec 24</u> 19 <u>68</u> to <u>Jan 19</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>Jan 18</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <u>Joseph E. Mark MD</u>					23B. DATE SIGNED			23C. PHYSICIAN'S NAME (Type) <u>Joseph E. Mark MD</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>					24B. DATE <u>1-20-69</u>		24C. NAME OF CEMETERY or CREMATORY <u>CHEVRA AHAVAS CHESSED</u>		24D. LOCATION (City, town, or county) (State) <u>ROSEDALE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 22 1969</u>			25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>			25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD</u>				

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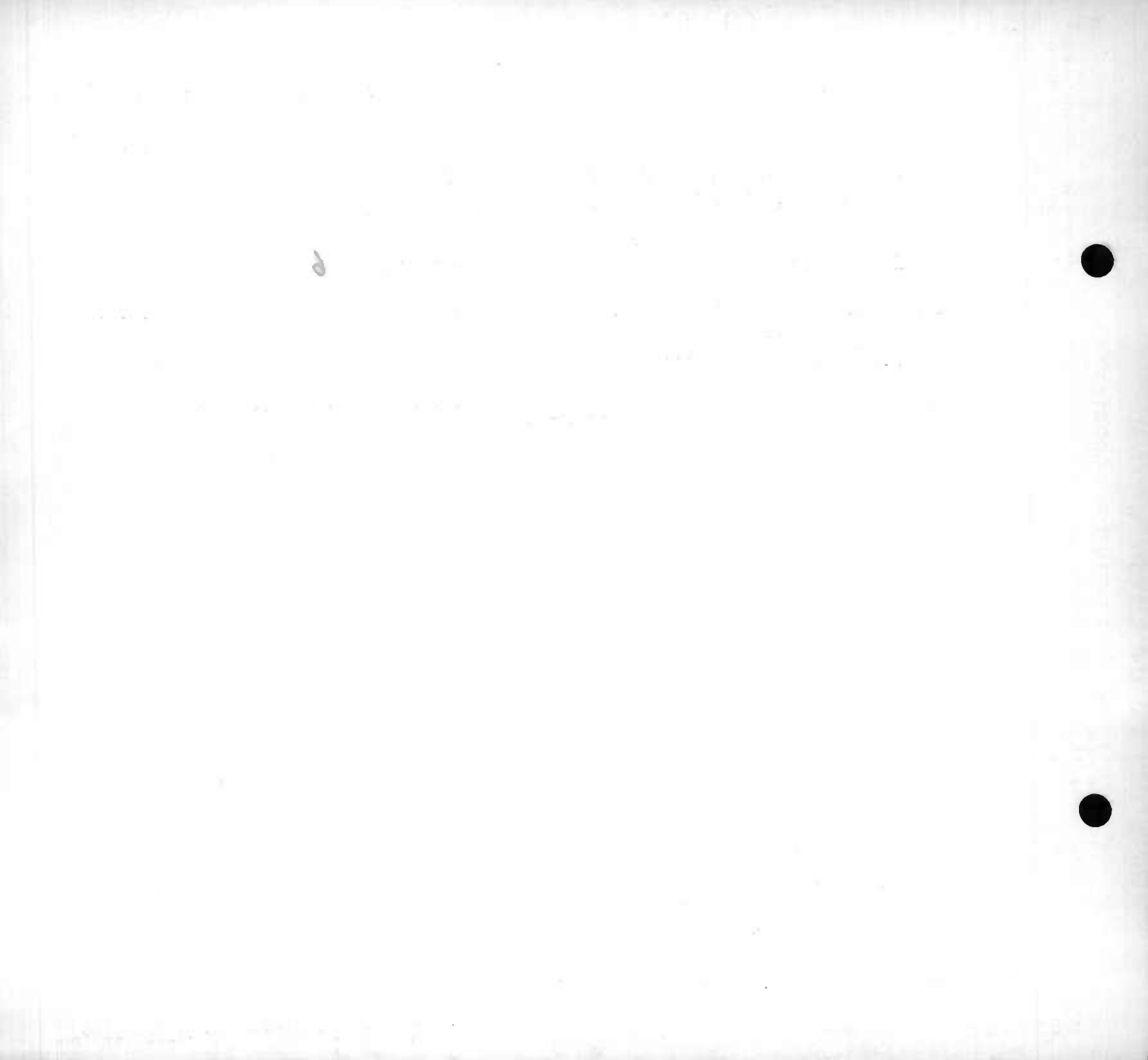
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0756		BALTIMORE CITY HEALTH DEPARTMENT		69 0756	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>PAUL ATKINSON</u>		2. DATE AND HOUR OF DEATH <u>JAN 21 - 1969 12:45 A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 THE JOHNS HOPKINS HOSPITAL</u> <u>BALTIMORE, MD 21205</u>		C. CITY OR TOWN <u>TIMONIUM</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>MALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>6-11-03</u>		9. AGE (In years last birthday) <u>65</u>		If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Manager</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Grain Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Michigan</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>O'Brien</u> <u>Atkinson</u>			
14. MOTHER'S MAIDEN NAME <u>Marie J Viger</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>488-09-4853</u>		17. INFORMANT ADDRESS <u>Margaret Atkinson, Same as # 4</u>			
18. CAUSE OF DEATH <u>410.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>MYOCARDIAL INFARCTION</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCAD</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>Jan 21 1969</u> to <u>Jan 21 1969</u> that (1) (we) last saw the deceased alive on <u>Jan 21 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>David A. Bass</u>		23B. DATE SIGNED <u>1/21/69</u>		23C. PHYSICIAN'S NAME (Type) <u>DAVID A. BASS</u>	
23D. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>		23E. DATE <u>JAN 22 1969</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>Jan. 24, 69</u>		24C. NAME of CEMETERY or CREMATORY <u>Dulaney Valley</u>	
24D. LOCATION (City, town, or county) (State) <u>Cockeysville, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 22 1969</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Wm. Cook Brooks</u>			
25D. ADDRESS <u>Towson, Maryland</u>		25E. DATE <u>0756</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <span style="float: right;">69 0757</span>	
1. NAME OF DECEASED (Type or Print) <u>Mr. Alfred J. Petersdorff</u>			2. DATE AND HOUR OF DEATH <u>11/21/69</u> <u>6-12 A</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>27-06</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Church Home &amp; Hospital</u> <u>35 Baltimore Maryland</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>8-3-89</u> 9. AGE (In years last birthday) <u>79</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired self employed</u>			11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>
13. FATHER'S NAME <u>Herz Petersdorff</u>			14. MOTHER'S MAIDEN NAME <u>FOX Marianne Fuchs</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>017-32-7558</u>		17. INFORMANT ADDRESS <u>Elfriede Petersdorff</u> <u>5305 Hamlet Ave</u> <u>21214</u>
18. <u>410.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Ventricular Fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF: <u>(cardiac arrest)</u> (B) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF: <u>5 days</u> <u>Pulmonary edema</u> (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <u>1-16-1969</u> to <u>1-21-1969</u> , that (H) (we) last saw the deceased alive on <u>1-21-1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Joseph Nidiry M.D.</u>			23B. DATE SIGNED <u>1-21-69</u>		23C. PHYSICIAN'S NAME (Type) <u>JOSEPH NIDIRY</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>1/22/69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Moteland Mem. Park</u>
24D. LOCATION (City, town, or county) (State) <u>Parkville, Md.</u>			25A. DATE REC'D BY HEALTH DEPT.		
25B. NAME OF REGISTRAR <u>Robert E. Tolson</u>			25C. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook-Brooks Towson</u> <u>1050 York Rd.</u> <u>Towson, Md.</u>		

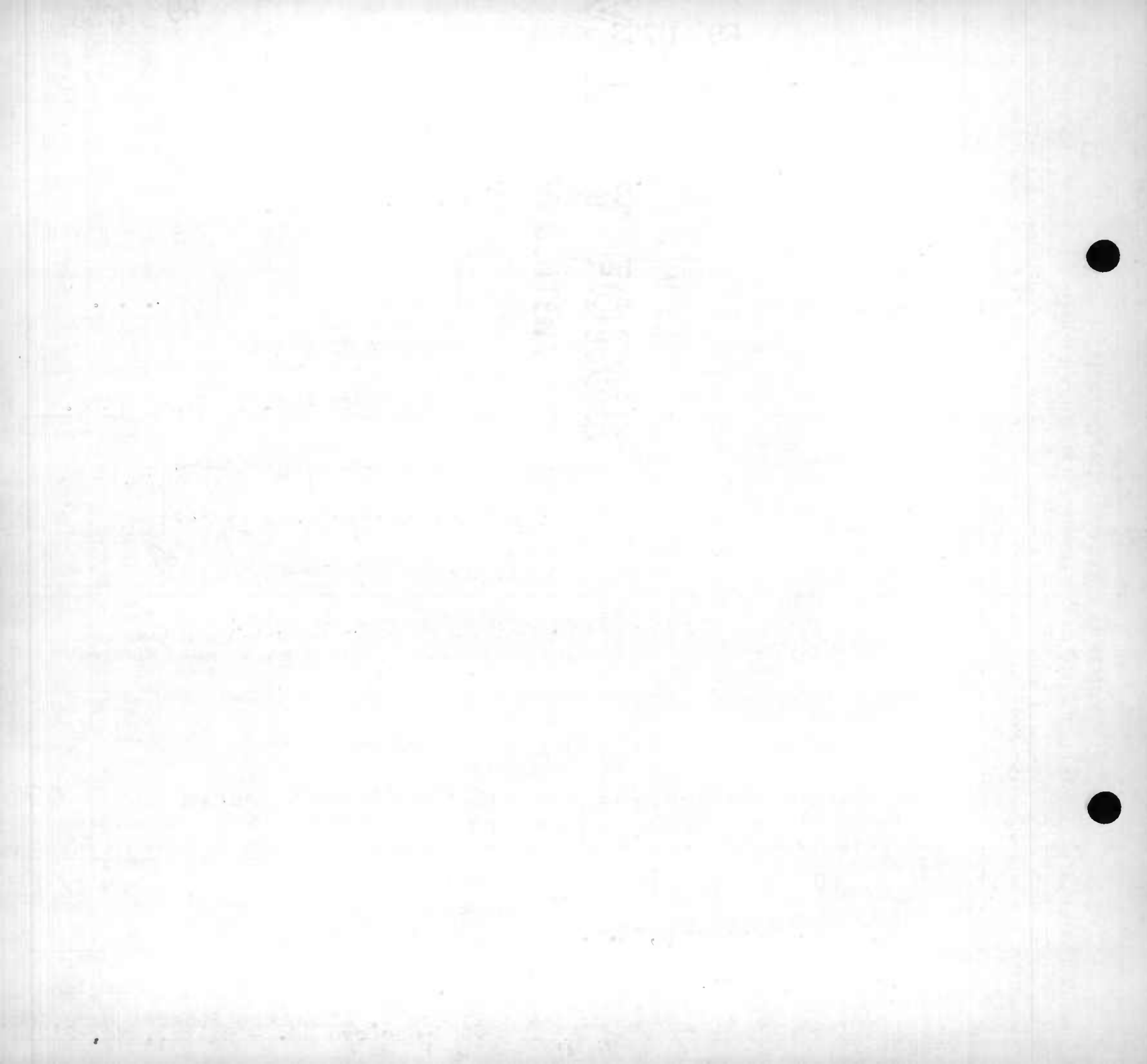
12-15-1

Adopted and passed

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Yakovlev

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">69 0758</span>	
<div style="display: flex; justify-content: space-between;"> <span>69 0758</span> <span>CERTIFICATE OF DEATH</span> </div>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Martha A. Akehurst		1/19/69		7 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
00 4505 Elsrade Ave.			Maryland		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			4505 Elsrade Ave.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	4/15/82	86	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Housewife			Maryland		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Benjamin Slaysman			Margaret Flayhart		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		213-09-9262		D Julia Fogle - 4505 Elsrade Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Coronary occlusion		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Coronary Sclerosis		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			arterio Sclerosis Heart		
			(C) Secondary Anemia Thrombosis		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Oct 16 1968 to Jan 19 1969, that (I) (we) last saw the deceased alive on Jan 19 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Walter A. Anderson				Jan 21 - 69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Walter A. Anderson, M.D.				3001 Shannon Dr.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		1/22/69		Lorraine Park Cem.	
				Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 22 1969		Robert E. Talley		Robert C. Altenburg Funeral Home, Inc. 6009 Harford Rd. - Balto., Md. 21214	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 0759	
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>BENJAMIN C. WILLIAMS</b>				<b>2. DATE AND HOUR OF DEATH</b> <b>1-19-69</b> <b>1:56 A.M.</b>	
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33 THE JOHNS HOPKINS HOSPITAL</b> <b>BALTIMORE, MD 21205</b>				<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) <b>A. STATE</b> <b>MARYLAND</b> <b>B. COUNTY</b> <b>ANNE ARUNDEL</b> <b>C. CITY OR TOWN</b> <b>GLEN BURNIE</b> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <b>1034 FITZALLEN ROAD</b>	
<b>5. SEX</b> <b>MALE</b>	<b>6. RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>10-11-09</b>	<b>9. AGE</b> (In years last birthday) <b>59</b>	<b>If Under 1 Yr. Months Days</b> <b>If Under 24 Hrs. Hours Min.</b>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>GUIDANCE COUNSELLOR</b>			<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>BALTO. CO. BD. OF ED.</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>HARNETT CO. N. CAROLINA</b>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			<b>13. FATHER'S NAME</b> <b>BENJAMIN</b>		
<b>14. MOTHER'S MAIDEN NAME</b> <b>NILA CURRY</b>			<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
<b>16. SOCIAL SECURITY NO.</b> <b>239-03-2753</b>			<b>17. INFORMANT</b> <b>MRS. EUVA J. WILLIAMS (wife)</b>		
<b>18. CAUSE OF DEATH</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>MASSIVE HEMORRHAGE</b> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Ruptured, Dissecting Aortic Aneurysm</b>			<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>		
<b>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>					
<b>19A. DATE OF OPERATION</b> <b>NONE</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <b>YES</b>	
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>			
<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21D. TIME OF INJURY</b> (APPROX.)		<b>21E. INJURY OCCURRED</b>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>21D. TIME OF INJURY</b> (APPROX.)		<b>21E. INJURY OCCURRED</b>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>1-17</b> <b>19 69</b> <b>to</b> <b>1-19</b> <b>1969</b> , <b>that (I) last saw the deceased alive on</b> <b>1-18</b> <b>19 69</b> <b>and that in my opinion death occurred on the date</b> <b>1-19</b> <b>1969</b> <b>and hour and from the causes stated above. (I) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <b>Vernon T. Tolo M.D.</b>				<b>23B. DATE SIGNED</b> <b>1/19/69</b>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>VERNON T. TOLO</b>				<b>23D. ADDRESS</b> <b>THE JOHNS HOPKINS HOSPITAL</b>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>24B. DATE</b> <b>JAN. 22/69</b>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>GLEN HAVEN MEMORIAL PARK</b>	
<b>24D. LOCATION</b> (City, town, or county) (State) <b>GLEN BURNIE, MARYLAND</b>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>JAN 22 1969</b>			
<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Seaborn</b>		<b>25C. FUNERAL DIRECTOR</b> <b>SINGLETON FUNERAL HOME</b>			
<b>25D. ADDRESS</b> <b>GLEN BURNIE, MARYLAND</b>					

MASS 4E RESEARCH

Engineer, District West Virginia

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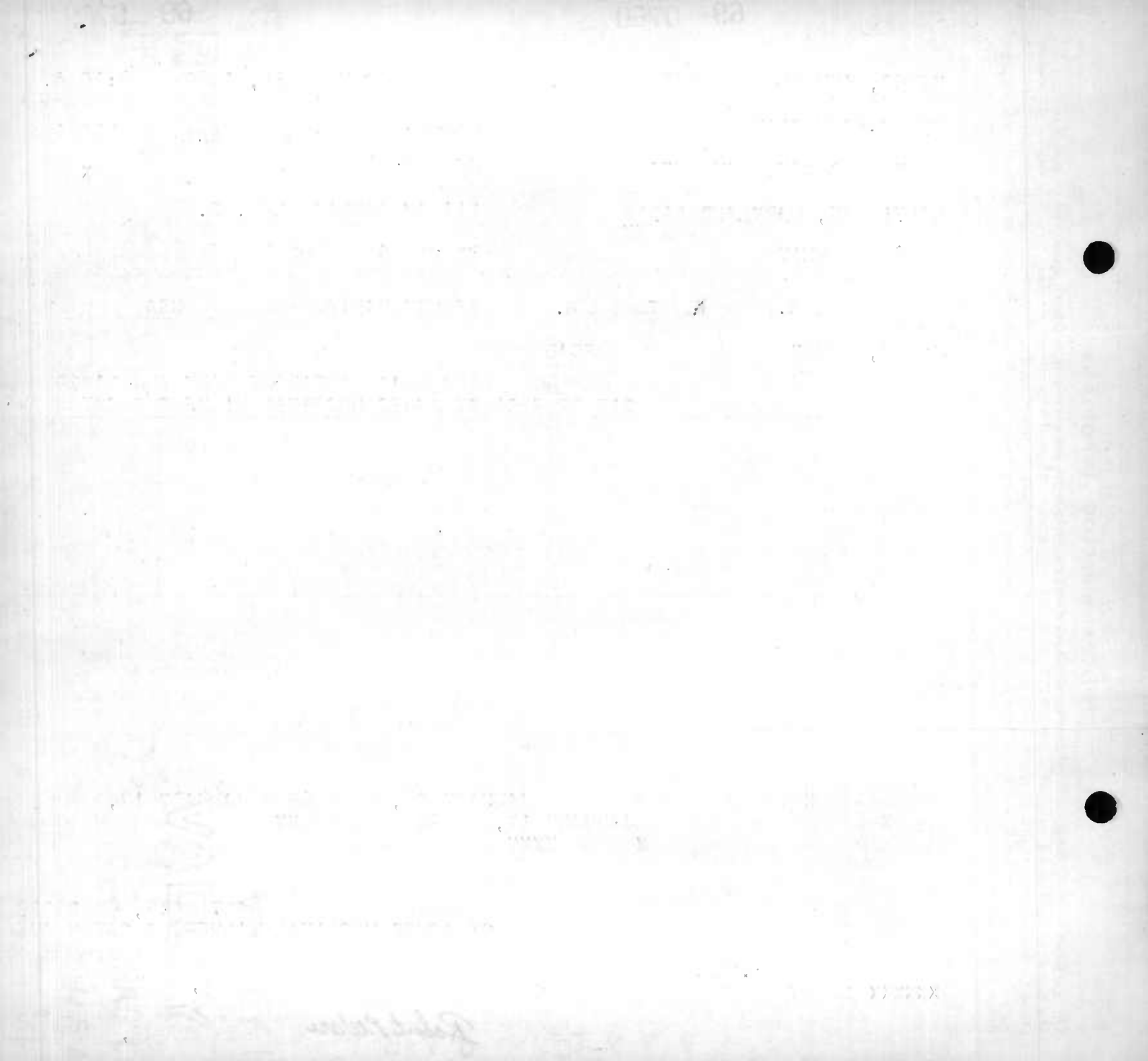
R. B. Smith



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>KEYES, STUART ROBERTSON</b>				2. DATE AND HOUR OF DEATH <b>JANUARY 17, 1969</b>				4:10 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>ST AGNES HOSPITAL</b> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>WILKENS &amp; CATON AVENUES</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>ANNE ARUNDEL</b> <b>21061</b>				C. CITY OR TOWN <b>FERDALE (GLEN BURNIE)</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER <b>211 ANNAPOLIS BLVD. S.</b>				5. SEX <b>MALE</b> 6. RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>02 08 86</b> 9. AGE (In years last birthday) <b>82</b>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN (ret.)</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>KEYSTONE INS.</b>				11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>HENRY, KEYES</b>				14. MOTHER'S MAIDEN NAME <b>DEC'D (UNKNOWN)</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>217 22 5834</b>				17. INFORMANT <b>RECORD'S BALTIMORE MARYLAND</b> ADDRESS <b>ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Surgutative Cholangitis</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Surgutative Cholangitis</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Carcinoma, Head of Pancreas</b>				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Carcinoma, Head of Pancreas</b>				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION <b>2</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <b>Yes</b>			
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from <b>JANUARY 08, 19 69</b> to <b>JANUARY 17, 19 69</b> , that (X) (we) lost saw the deceased alive on <b>JANUARY 17, 1969</b> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.											
23A. SIGNATURE <b>Romualdo B. Dator, M.D.</b>				23B. DATE SIGNED <b>1-17-69</b>							
23C. PHYSICIAN'S NAME (Type) <b>Romualdo B. Dator, M.D.</b>				23D. ADDRESS <b>BALTIMORE, MD 21229</b> <b>ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>CREMATION</b>				24B. DATE <b>JAN. 21/69</b>				24C. NAME OF CEMETERY or CREMATORY <b>LOUDDON PARK</b>			
24D. LOCATION <b>BALTIMORE, MARYLAND</b>				25A. DATE REC'D BY HEALTH DEPT. <b>JAN 22 1969</b>				25B. NAME OF REGISTRAR <b>Robert E. Farnham</b>			
25C. FUNERAL DIRECTOR <b>Robert Pulone</b>				25D. ADDRESS <b>SINGLETON FUNERAL HOME</b> <b>GLEN BURNIE, MARYLAND</b>							



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 0761	
1. NAME OF DECEASED (Type or Print) <b>DONALD MURRAY</b>			2. DATE AND HOUR OF DEATH <b>1-19-1969 12.45P M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>26-05</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>			C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <b>338 Folcroft Street 21224</b>					
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-13-1905</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Vermont</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Jerry MURRAY</b>			14. MOTHER'S MAIDEN NAME <b>Virginia</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO -</b>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Records: BCH-4940 Eastern Avenue 21224</b>
18. <b>4-12-31</b> CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE <b>PULMONARY EMBOLISM</b> DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <b>CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF:		
			(C) <b>Arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			<b>MULTIPLE MYOCARDIAL INFARCTIONS</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>1/15/69</b> 19 to <b>1/19/69</b> 19, that (2) (we) last saw the deceased alive on <b>1/19/69</b> 19, and that (3) (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>David Acker M.D.</b>				23B. DATE SIGNED <b>1/19/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>DAVID ACKER M.D.</b>				23D. ADDRESS <b>Baltimore City Hospitals 4940 EASTERN AVE BALTIMORE</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>22 JAN 69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>LOXDON PARK CEMETERY</b>	
24D. LOCATION (City, town, or county) <b>BALTO. MD.</b>		24E. (State) <b>BALTO. MD.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 22 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>ULLRICH FUNERAL HOME, DUNDALK, MD</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 0762

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>HELEN BAKER</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>January 17, 1969</b> Hour <b>2:27 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>44 UNION MEMORIAL HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 17, 1969 2:27 A.M.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>12-07</b>			
6. SEX <b>Female</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>JUNE 21, 1898</b>		10. AGE (In years last birthday) <b>70</b>	
11. BIRTHPLACE (State or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>-</b>	
18. INFORMANT <b>Catherine Newton</b>		ADDRESS <b>21220 Box 479 R 16 Chase, Md</b>	
19. <b>E 814.17</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH <b>Multiple Traumatic Injuries</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>28th St. E. of Hampden Avenue</b>		22F. HOW DID INJURY OCCUR? <b>Pedestrian struck by car</b>	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>Jan. 1, 1969 4:05 P. m.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>  DATE SIGNED <b>1/17/69</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Jan 20, 1969</b>	
24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 22 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Sweeney</b>	
25C. FUNERAL DIRECTOR <b>Burgee Funeral Home</b>		ADDRESS <b>Baltimore Md</b>	

June 21, 1911  
June 21, 1911

June 21, 1911  
June 21, 1911

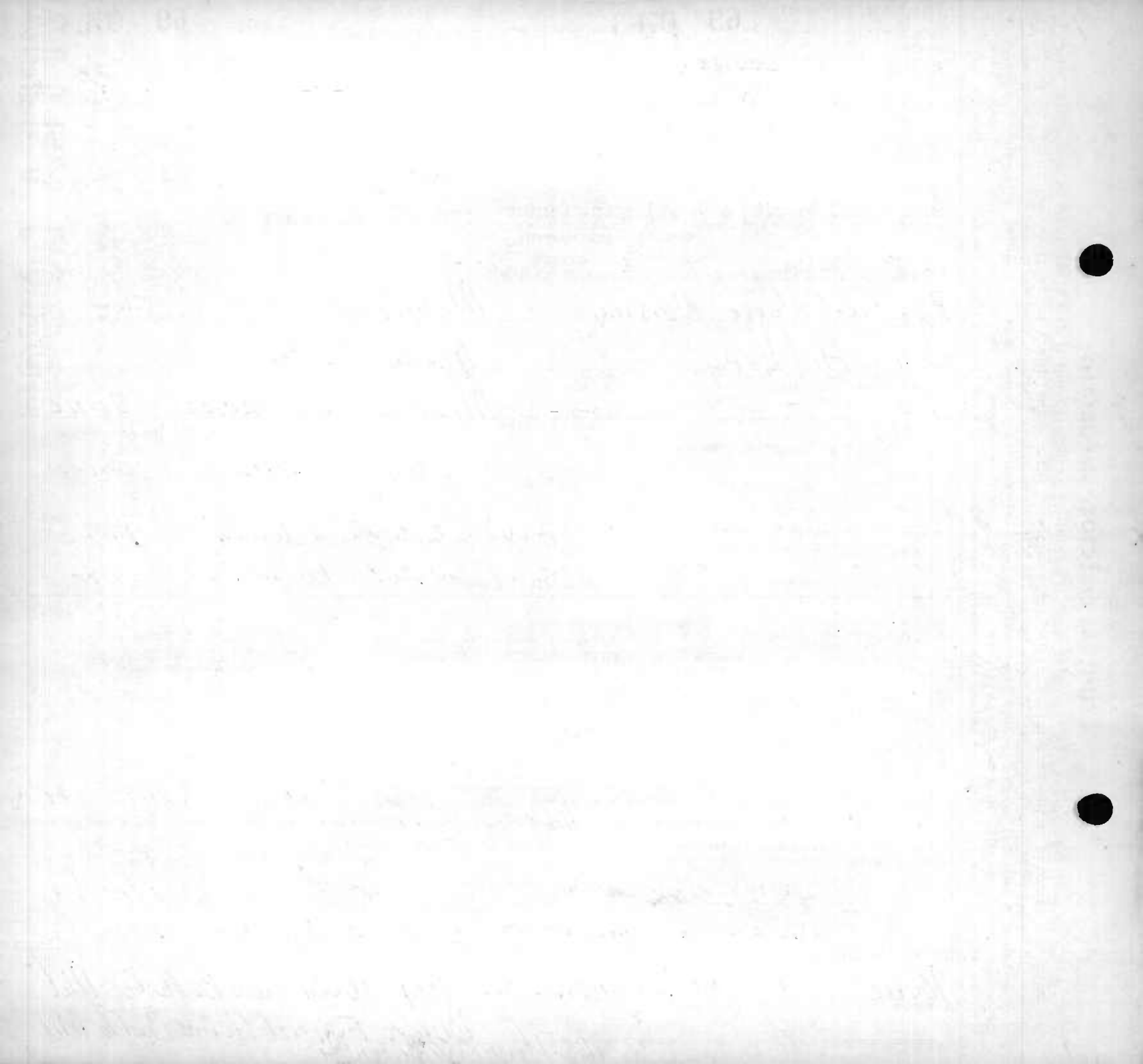
June 21, 1911  
June 21, 1911

June 21, 1911  
June 21, 1911

June 21, 1911  
June 21, 1911

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0763				BALTIMORE CITY HEALTH DEPARTMENT				69 0763			
BIRTH NO.				1. NAME OF DECEASED				2. DATE AND HOUR OF DEATH			
				<i>LOUISE Ella Ruby</i>				1-17-69 8:50 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				27-57			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				Maryland				C. CITY OR TOWN			
70 Bolton Hill Nursing & Convalescent Center				Baltimore				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX				6. RACE				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			
Female				White				WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
10A. USUAL OCCUPATION (Give kind of work during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				8. DATE OF BIRTH			
Practical Nurse				Nursing				4-3-77			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				9. AGE (In years last birthday)			
John Hillberg				Mary Foster				91			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT			
No				215-54-2156				Mrs Hazel R. Schreier			
18. CAUSE OF DEATH				19. ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				weeks			
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)				actual fibrillation				weeks			
ANTECEDENT CAUSES				(B) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				years			
Antemortem to heart disease				DUE TO, OR AS A CONSEQUENCE OF:				years			
Sudden and unexpected				DUE TO, OR AS A CONSEQUENCE OF:				weeks			
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
0								20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)				White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 1/16 19 69 to 1/17 19 69, that (I) (we) last saw the deceased alive on 1/17 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE				23B. DATE SIGNED			
al [Signature]				Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>				1/17/69			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS				24A. BURIAL CREMATION, REMOVAL (Specify)			
ALLAN H. MACHT MD				2 E. READ ST BALTIMORE				1-21-69			
24B. DATE				24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
1-21-69				Woodlawn Cemetery				Woodlawn Bldg Co Md			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR			
JAN 22 1969				Robert E. [Signature]				Burgess Funeral Home Balto Md			





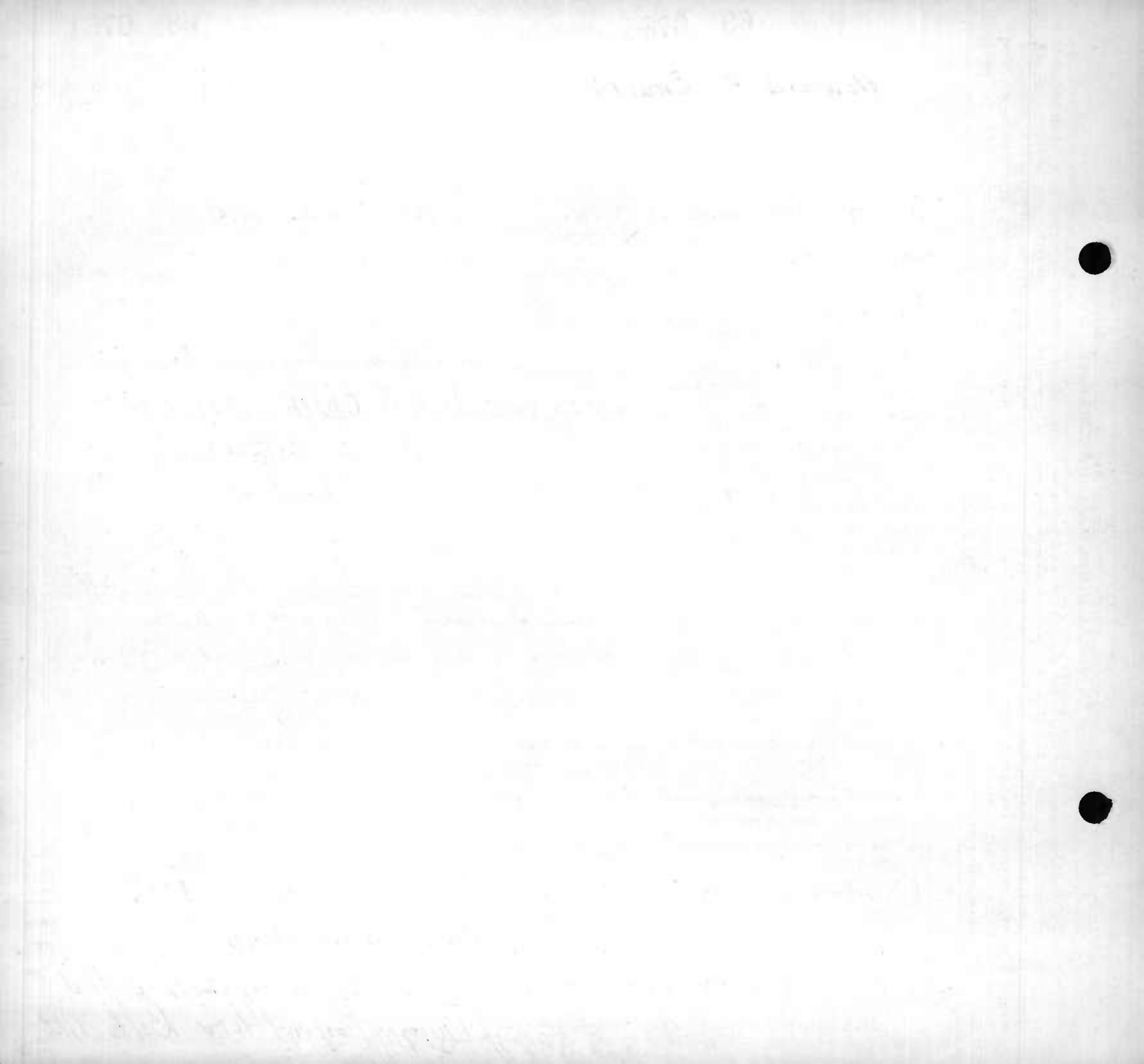
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. **69 0764**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Howard F. Chalk</b>		2. DATE AND HOUR OF DEATH <b>JAN 17, 1969 14:35 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>44 Union Memorial Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO.</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3998 Rolano Ave.</b>		
5. SEX <b>male</b>	6. RACE <b>LAUL.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>07/08/06</b>	9. AGE (In years last birthday) <b>62</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>JOHN CHALK</b>			14. MOTHER'S MAIDEN NAME <b>ROSE GILL</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217 05 9435</b>		17. INFORMANT <b>JACK W Chalk</b> ADDRESS <b>1128 W 43rd St</b>	
18. <b>483 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Compunct from chole pneumonia</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>fracture</b> (C) <b>eff.</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			<b>Arteriosclerosis Cardiovascular</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>01/11</b> 19 <b>69</b> to <b>01/17</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>01/17</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Richard C. V. Hall M.D.</b>				23B. DATE SIGNED <b>1-17</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>Union Mem Hosp</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1-21-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Popter Grove Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Warren, Balto Co Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 22 1969</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Burgess Funeral Home Balto Md</b>			



W-362

69 0765 BALTIMORE CITY HEALTH DEPARTMENT

69 0765

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

PERCIVAL E. WOOTERS

2. DATE  
OF  
DEATHKnown ☐ Estimated ☒

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

University Hospital (DOA)

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

January 18, 1969

7:00 P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

Prince Georges

66-00

C. CITY OR TOWN

Baltimore (Laurel)

D. INSIDE CITY LIMITS?

YES ☒NO ☐

6. SEX

male

7. RACE

white

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

2-27-1911

10. AGE (In years  
last birthday)

57

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

3573 Ft. Meade Road

11. BIRTHPLACE (State or foreign country)

Richmond, Va.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

P.C. Wooters

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

14B. KIND OF BUSINESS OR INDUSTRY

Army

15. MOTHER'S MAIDEN NAME

Mary

Northern

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WW II

17. SOCIAL  
SECURITY NO.

18. INFORMANT

Ida Wooters

3573 Ft. Meade Rd.

19. 412.4

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/19/69

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Burial

1-22-69

Gerardtown Pres.

Gerardstown

W. Va.

JAN 22 1969

Robert E. Jackson

Higinbotham-Slack  
Funeral HomeEllicott City  
Md.

WALSH & CO.

W. B. Walsh

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0766 BALTIMORE CITY HEALTH DEPARTMENT  
BIRTH NO. 69 0766 CERTIFICATE OF DEATH

REG. NO. 69 0766

BIRTH NO. 1. NAME OF DECEASED (Type or Print) <b>GILFORD GEE</b>		2. DATE AND HOUR OF DEATH <b>Jan. 22, 1969 6:10 a. m.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>46 LUTHERAN HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>16-04</b>	
		C. CITY OR TOWN <b>BALTIMORE</b>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <b>604 N. MONROE ST</b>	
5. SEX <b>M</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 5, 1929</b>
		9. AGE (In years lost birthday) <b>39</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Blacktop Gangman</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>107 N. MOUNT ST. BALTO MD U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>SNOW GEE</b>		14. MOTHER'S MAIDEN NAME <b>MARIE AUSTIN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes 3/29/48 - 3-29-52</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>GLORIA GEE (WIFE)</b>		ADDRESS <b>604 N MONROE ST</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CEREBRO VASCULAR ACCIDENT - HOURS</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>HYPERTENSION</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan. 22 1969</b> to <b>Jan. 22 1969</b> , that (II) (we) lost saw the deceased alive on <b>Jan. 22 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Manuel J. Tan</b> DEGREE			23B. DATE SIGNED <b>Jan. 22, 1969</b>
23C. PHYSICIAN'S NAME (Type) <b>MANUEL J. TAN</b> DEGREE		23D. ADDRESS <b>LUTHERAN HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <b>Jan 22/69</b>	24C. NAME OF CEMETERY or CREMATORY <b>BALTO NATIONAL</b>	24D. LOCATION (City, town, or county) (State) <b>BALTO MD</b>
25A. DATE RECEIVED <b>JAN 22 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>	25C. FUNERAL DIRECTOR <b>Manuel J. Tan</b> ADDRESS <b>604 N MONROE ST</b>

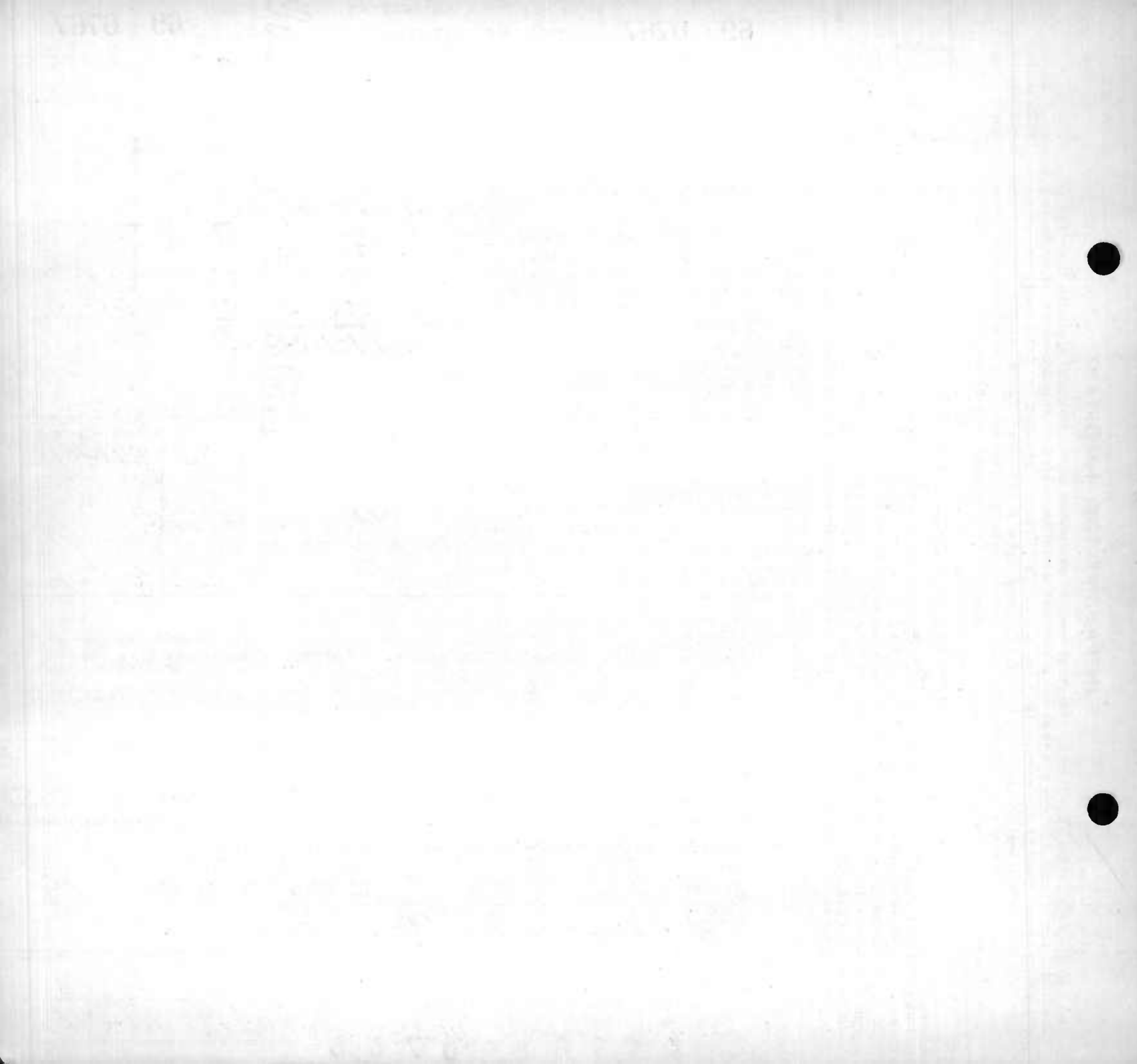


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
69 0767 CERTIFICATE OF DEATH

REG. NO. 69 0767

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>RYAN, ESTELLE</b>		2. DATE AND HOUR OF DEATH <b>Jan 19, 1969 1230 PM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>44 Union Men. Hosp</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>12-03</b>	
5. SEX <b>F</b>		6. RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>OKLAHOMA</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-18-5548</b>		17. INFORMANT <b>Denother Spinner 2451 Barclay St.</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Resp. ARREST</b> DUE TO, OR AS A CONSEQUENCE OF: <b>M.I. ? pulm. embolism ?</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>coronary dis. diab. gangrene</b> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>31 Dec 68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>diabetic gangrene</b>		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Dec. 20 1968</b> to <b>Jan 19 1969</b> , that (I) (we) last saw the deceased alive on <b>midnight Jan 18 69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Bienvenido B. Capati</b>				23B. DATE SIGNED <b>Jan 19-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Bienvenido B. CAPATI</b>				23D. ADDRESS <b>Union Men. Hosp.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-22-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Anne Arundel Cty. Md.</b>		25A. DATE RECD. BY HEALTH DEPT. <b>JAN 22 1969</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>W.C. MARCH 928 E. North Ave</b>			





# FUNERAL DIRECTOR: IMPORTANT

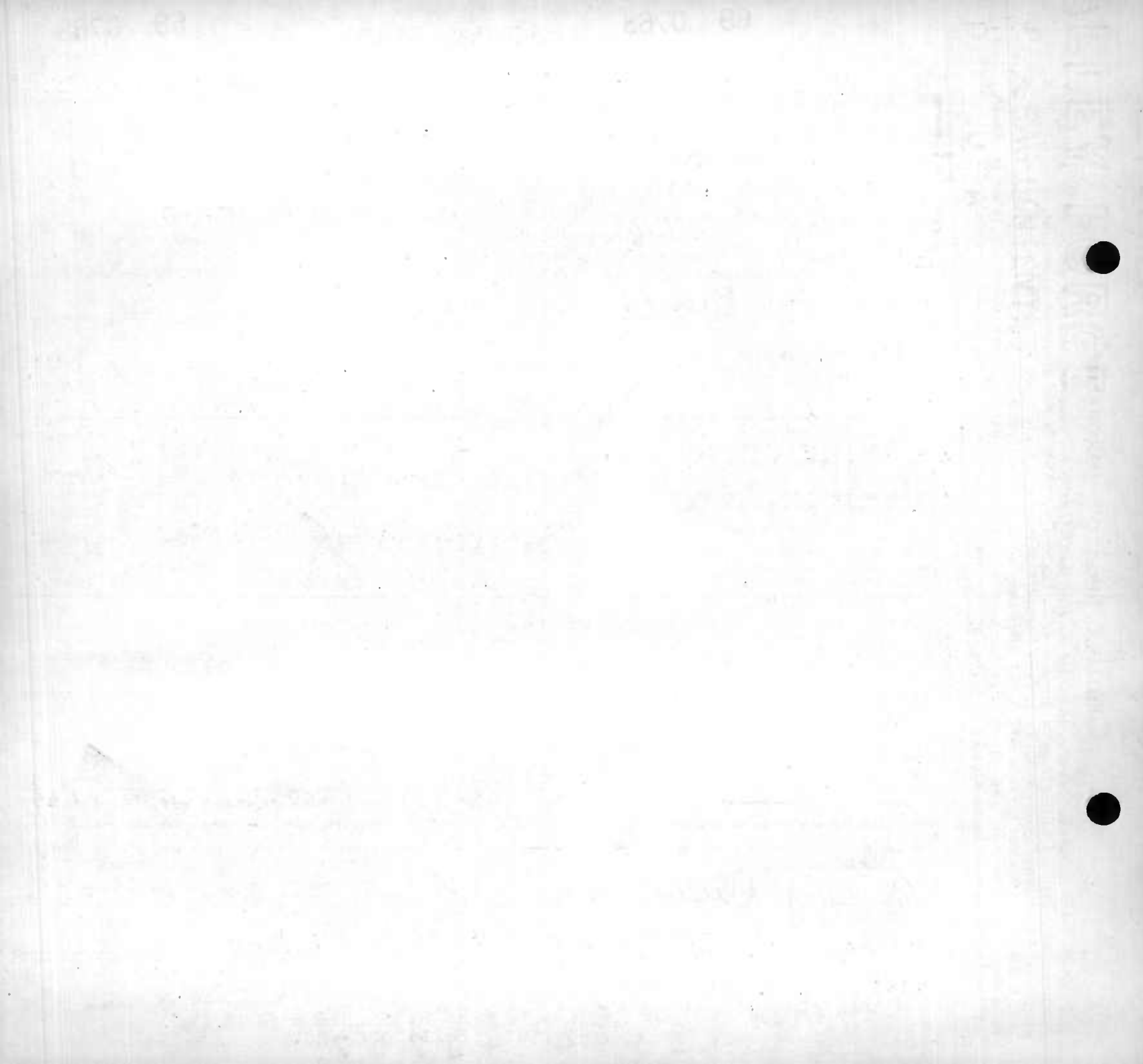
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0768

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 69 0768

BIRTH NO.		1. NAME OF DECEASED (Type or Print) (WILLARD HENRY OWENS.Sr.) <b>WILLARD OWENS</b>		2. DATE AND HOUR OF DEATH <b>JANUARY 20, 1969 12:35 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>9-07</b>		C. CITY OR TOWN <b>BALTIMORE 21218</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 5837 BELAIR-ROAD</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>House. of The Pine-Belair</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Repairman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>(Self Employed)</b>		8. DATE OF BIRTH <b>Oct. 19. 1888</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		9. AGE (In years last birthday) <b>80</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William S. Owens</b>		14. MOTHER'S MAIDEN NAME <b>Sophia Blades</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>218 28 4108A</b>		17. INFORMANT <b>Mrs. Hannah E. Owens (wife)</b>		ADDRESS <b>1743 Montpelier St. Baltimore 21218</b>	
18. <b>412.2.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Edema</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cordis Vasculor Hypertensio Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerosis</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>10 years</b>		(C) <b>10 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>the hospital</del> ) attended the deceased from <b>May 19 59</b> to <b>Jan. 20, 19 69</b> , that (I) (we) last saw the deceased alive on <b>January 19, 19 69</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>and</del> ) view the body after death.					
23A. SIGNATURE <b>Michael J. Dausch, M.D.</b>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>1-20-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Michael J. DAUSCH, M.D.</b>		23D. ADDRESS <b>4636 BELAIR-ROAD</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Jan. 23. 1969</b>		24C. NAME of CEMETERY or CREMATORY <b>Immanuel Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore Md.</b>		24E. STATE (State) <b>Md.</b>			
25A. DATE RECEIVED HEALTH DEPT. <b>JAN 22 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Galyon</b>		25C. FUNERAL DIRECTOR <b>HENRY SANDER &amp; SONS, INC.</b>	
ADDRESS <b>Baltimore Md.</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="float: right;">69 0769</span>
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Fred M. Curry</u>		2. DATE AND HOUR OF DEATH <u>11/21/69</u> <u>205</u> P. M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>ST.</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Community of Md.</u>		C. CITY OR TOWN <u>Ba 102</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER <u>755 W. Lexington St. Apt. 901</u> <u>5-01</u>		
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/18/28</u> 9. AGE (In years last birthday) <u>40</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Chauffeur</u>		11. BIRTHPLACE (State or foreign country) <u>Northumberland, Va.</u>
13. FATHER'S NAME <u>McKinley Curry</u>		14. MOTHER'S MAIDEN NAME <u>Alvira ?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u> <u>MMXX Korean War</u>		16. SOCIAL SECURITY NO. <u>231-30-5715</u>		17. INFORMANT <u>Mrs. Ruby R. Curry</u> ADDRESS <u>Hospital Information Sheet</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Gram negative septicemia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Intracerebral abscess</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>G.I. bleeding of ? etiology 12/68</u>				
19A. DATE OF OPERATION <u>12-14-68</u> <u>12-16-68</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>G.I. bleeding</u>	20A. AUTO? (Yes or No) <u>YPI</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>12/69</u> 19 <u>68</u> to <u>1/21</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>1/21</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Marvin C. Sachs MD</u>				23B. DATE SIGNED <u>1-21-69</u>
23C. PHYSICIAN'S NAME (Type) <u>MARVIN C. SACHS</u>				23D. ADDRESS <u>Univ. Hosp.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>1-24-1969</u>	24C. NAME of CEMETERY or CREMATORY <u>Baltimore National</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE RECEIVED BY HEALTH DEPT. <u>JAN 23 1969</u>		25B. NAME OF REGISTRAR <u>John E. Johnson</u>	25C. FUNERAL DIRECTOR <u>1735 Harford Ave. 21213</u> <u>Marshall W. Jones, Jr.</u>	

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 69 0770

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>LEVI MERCER</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>January 19, 1969</b> Hour <b>10:30 P.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>37 MERCY HOSPITAL</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 19, 1969 10:30 P.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>10/15/33</b>		10. AGE (In years last birthday) <b>35</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Torbor, N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		17. SOCIAL SECURITY NO. <b>245-48-874</b>	
18. INFORMANT <b>JAMES Mercer</b>		ADDRESS <b>1811 Harford Ave Baltimore</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Lobar pneumonia</b>		CAUSE OF DEATH <b>Lobar pneumonia</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Fatty metamorphosis of liver</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>1</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1/20/69</b> ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1/24/69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Community Cemetery Torbor N.C.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>1/23/69</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>	
25C. FUNERAL DIRECTOR <b>J.B. Johnson</b>		ADDRESS <b>Baltimore Md.</b>	

11/5/33  
To Mr. H.C. [unclear]  
Steel  
Blanche Taylor  
Tomball, Texas

Final 11/4/34 Community Center, H.C.  
[unclear]

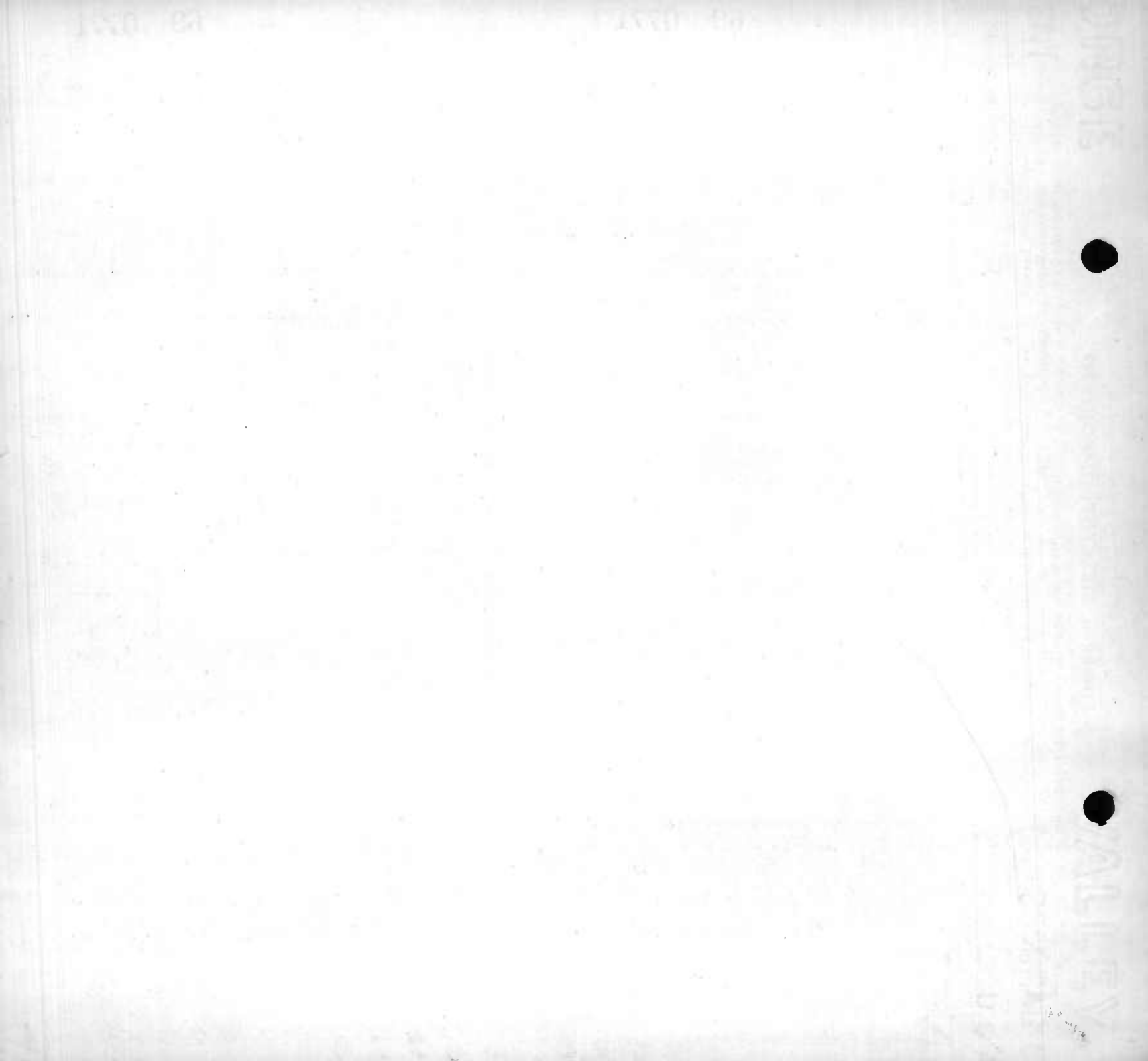
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0771

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 0771

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Charles Hanes</i>		2. DATE AND HOUR OF DEATH <i>January 18 1969 6 A M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission) A. STATE <i>Maryland</i> COUNTY <i>14-02</i>		C. CITY OR TOWN <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>00119 Lawrence St.</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Male</i>		6. RACE <i>Colored</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>None</i>		8. DATE OF BIRTH <i>Dec 28 1899</i> 9. AGE (In years last birthday) <i>70</i>	
13. FATHER'S NAME <i>Charles Hanes</i>		14. MOTHER'S MAIDEN NAME <i>St Mary B mel</i>		11. BIRTHPLACE (State or foreign country) <i>St Mary B mel</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Carrie Hanes Lane</i>	
18. <i>1621 I</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Carcinoma of Lung</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 1960</i> 19 <i>Jan 18</i> 1969, that (I) (we) last saw the deceased alive on <i>Jan. 15</i> 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>M.W. Jacobson MD</i>		23B. DATE SIGNED <i>1-21-69</i>		23C. PHYSICIAN'S NAME (Type) <i>M.W. JACOBSON MD</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-30-69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Harlock Oak</i>	
24D. LOCATION (City, town, or county) (State) <i>Easton, Anne Arundel Co, Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 22 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>	
25C. FUNERAL DIRECTOR <i>Gray Gibson 1000 Brandywine</i>					





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 0772

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>ROBERT H. PACE</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>42 Sinai Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 20, 1969 12:00 AM</b>	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>27-16</b>	
9. DATE OF BIRTH <b>July 11-1951</b>		10. AGE (In years last birthday) <b>18</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Budapest</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Pace Sr.</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>many leather</b>	
15. MOTHER'S MAIDEN NAME <b>Mary Pace</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>219-52-6444</b>		18. INFORMANT <b>Mary Pace</b>	
19. CAUSE OF DEATH <b>304.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Narcotics Addiction</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Russell S. Fisher</b> M.D. EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1/21/69</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-25-69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>McCarroll</b>		24D. LOCATION (City, town, or county) (Store) <b>at a family</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 22 1969</b>		25B. NAME OF REGISTRAR <b>Russell S. Fisher</b>	
25C. FUNERAL DIRECTOR <b>Elmer D. Walker</b>		ADDRESS <b>1969 0000 771</b>	

PA 0115

0115 02

WALBURY HOUSE

23/END CONTENT

1 X 1

WALBURY HOUSE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 0773

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HARVEY STANTON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> January 16, 1969 3:30 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JOHNS HOPKINS HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year January 16, 1969 3:30 P. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH January 2-1908		10. AGE (In years lost birthday) 61	
11. BIRTHPLACE (State or foreign country) Bennettsville S.C.		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work, even if retired) Retired		15. MOTHER'S MAIDEN NAME Aberta Bennett	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) No		17. SOCIAL SECURITY NO.	
18. INFORMANT Aberta Bennett		ADDRESS Same	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: [Signature] M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1/16/69			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-21-69	
24C. NAME OF CEMETERY or CREMATORY Arnon Temple Cmt		24D. LOCATION (City, town, or county) (State) South Carolina	
25A. DATE REC'D BY HEALTH DEPT. JAN 22 1969		25B. NAME OF REGISTRAR Robert E. Farley, M.D.	
25C. FUNERAL DIRECTOR Glenk & Home		ADDRESS South Carolina	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0774

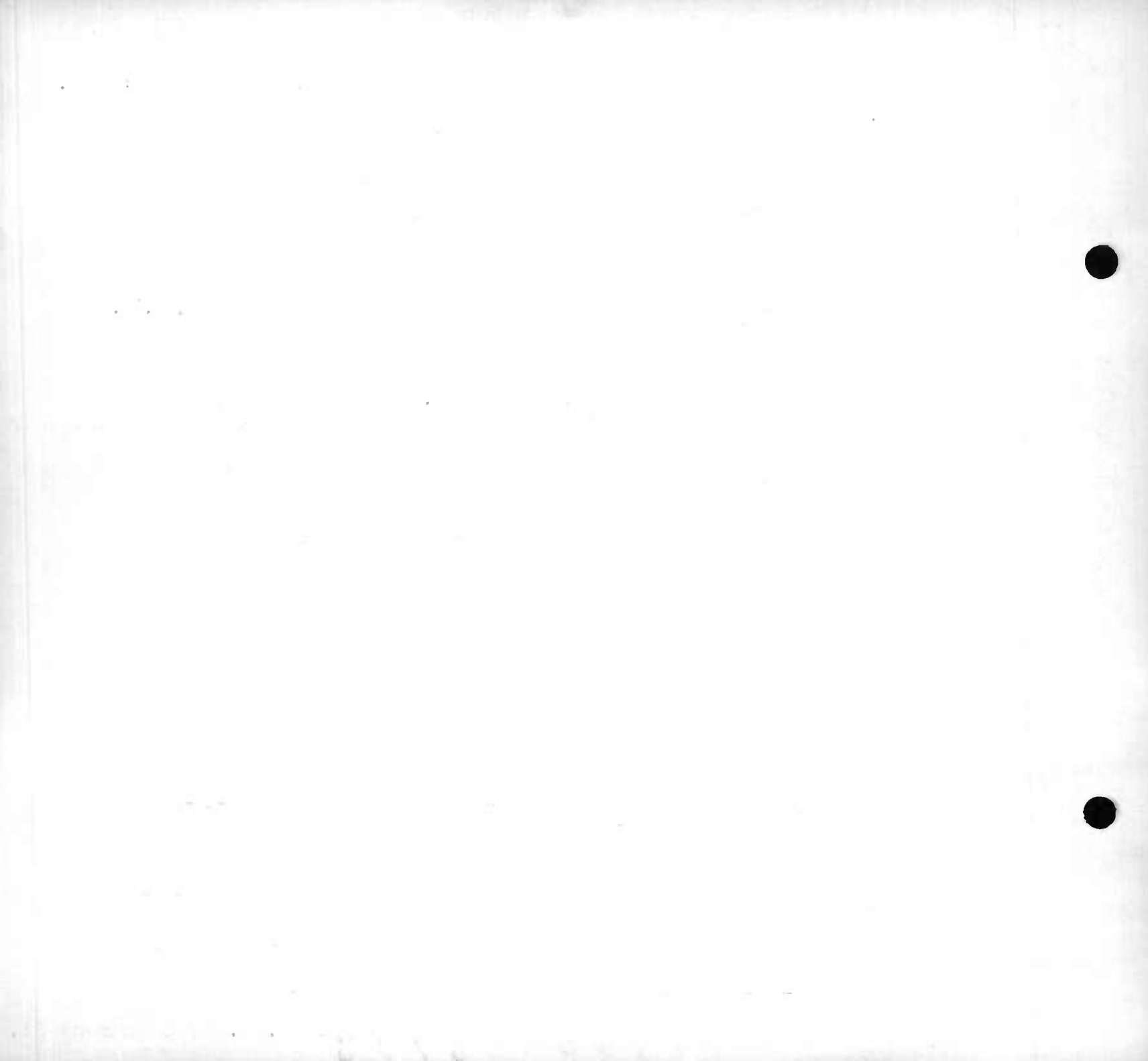
BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

69 0774

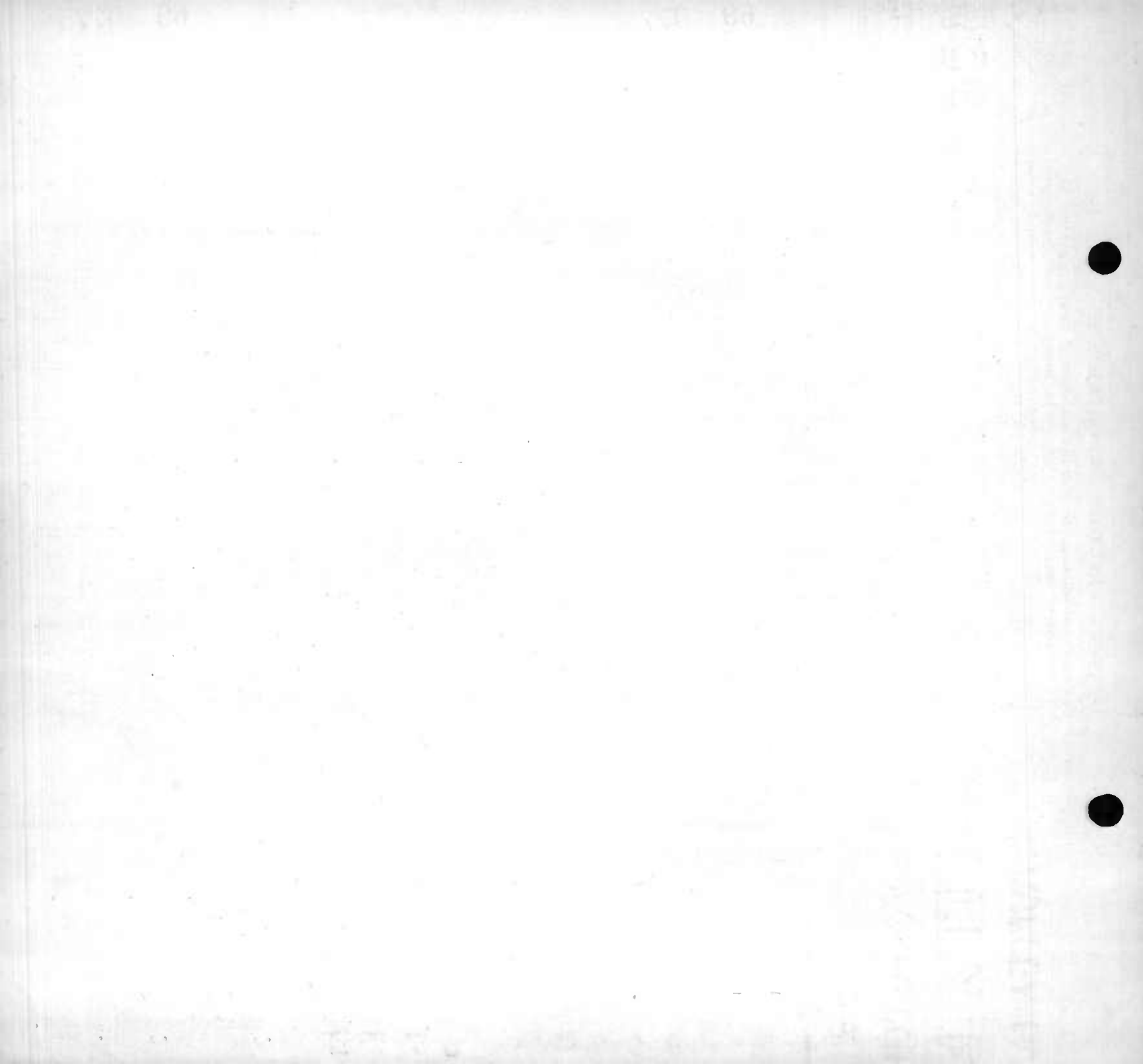
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Wilson, Frank (FRANCIS)</b>		2. DATE AND HOUR OF DEATH <b>1-19-69 9:45 a.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>Provident Hospital</b> ADDRESS OR LOCATION <b>1514 Division Street Baltimore, Maryland</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>16-02</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1325 Mosher Street</b>	
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-5-86</b>	9. AGE (In years last birthday) <b>86</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>?</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>SYE WILSON</b>		14. MOTHER'S MAIDEN NAME <b>UNKN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212052092A</b>		17. INFORMANT <b>Mrs. Thelma Mack (niece) Francis Wilson, Son 2100 Turnage Av</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Semibity</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pulmonary edema</b> (B) <b>Congestive Heart failure</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1-7-69</b> to <b>1-19-69</b> that (I) (we) last saw the deceased alive on <b>1-19-69</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ahsan S. Khan</b>				23B. DATE SIGNED <b>1-20-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>AHSAN S. KHAN</b>		23D. ADDRESS <b>Provident Hospital 1514 Division Street - Baltimore, Maryland</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1-23-69</b>	24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1969</b>		25B. NAME OF REGISTRAR <b>Robert C. [unclear]</b>		25C. FUNERAL DIRECTOR <b>Morton &amp; Dyett F. H. 1701 Laurens St.</b>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">69 0775</span>	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>SALINA TAYLOR</b>		2. DATE AND HOUR OF DEATH <b>January 17, 1969</b> <span style="float: right;">2:40 a.m.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>13-02</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>48 Maryland General Hospital</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>2215 Eutar Place</b>		
5. SEX <b>F</b>	6. RACE <b>N N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 13, 1919</b>	9. AGE (In years last birthday) <b>49</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Wilmer Denton</b>		14. MOTHER'S MAIDEN NAME <b>Gantt</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Salina - Taylor's Chart</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>Peritonitis</b>		CAUSE OF DEATH <b>Peritonitis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 Wks</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Perforated viscus</b>		<b>3 weeks</b>	
		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Peritonitis</b>		<b>2 weeks</b>	
		(C) DUE TO, OR AS A CONSEQUENCE OF: <b>Abdominal Viscus</b>		<b>20 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<b>carcinoma of Cervix (?), 2</b>		<b>Radiation Therapy</b>	
19A. DATE OF OPERATION <b>11-20-68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Perforated Viscus &amp; Peritonitis</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>no</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>-</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>-</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>-</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>-</b>	
22. I certify that (H) (this hospital) attended the deceased from <b>November 13, 1968</b> to <b>January 17, 1969</b> , that (H) (we) last saw the deceased alive on <b>January 17, 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Terren M. Himelfarb MD</b>				23B. DATE SIGNED <b>Jan 17, 1969</b>	
23C. PHYSICIAN'S NAME (Type) <b>TERREN M. HIMELFARB MD</b>				23D. ADDRESS <b>Maryland General Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1-22-69</b>	24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 22 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Morton &amp; Dyett Funeral Homes, Inc</b>	
				ADDRESS <b>1001 Laurens St., Balto., Md. 21217</b>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

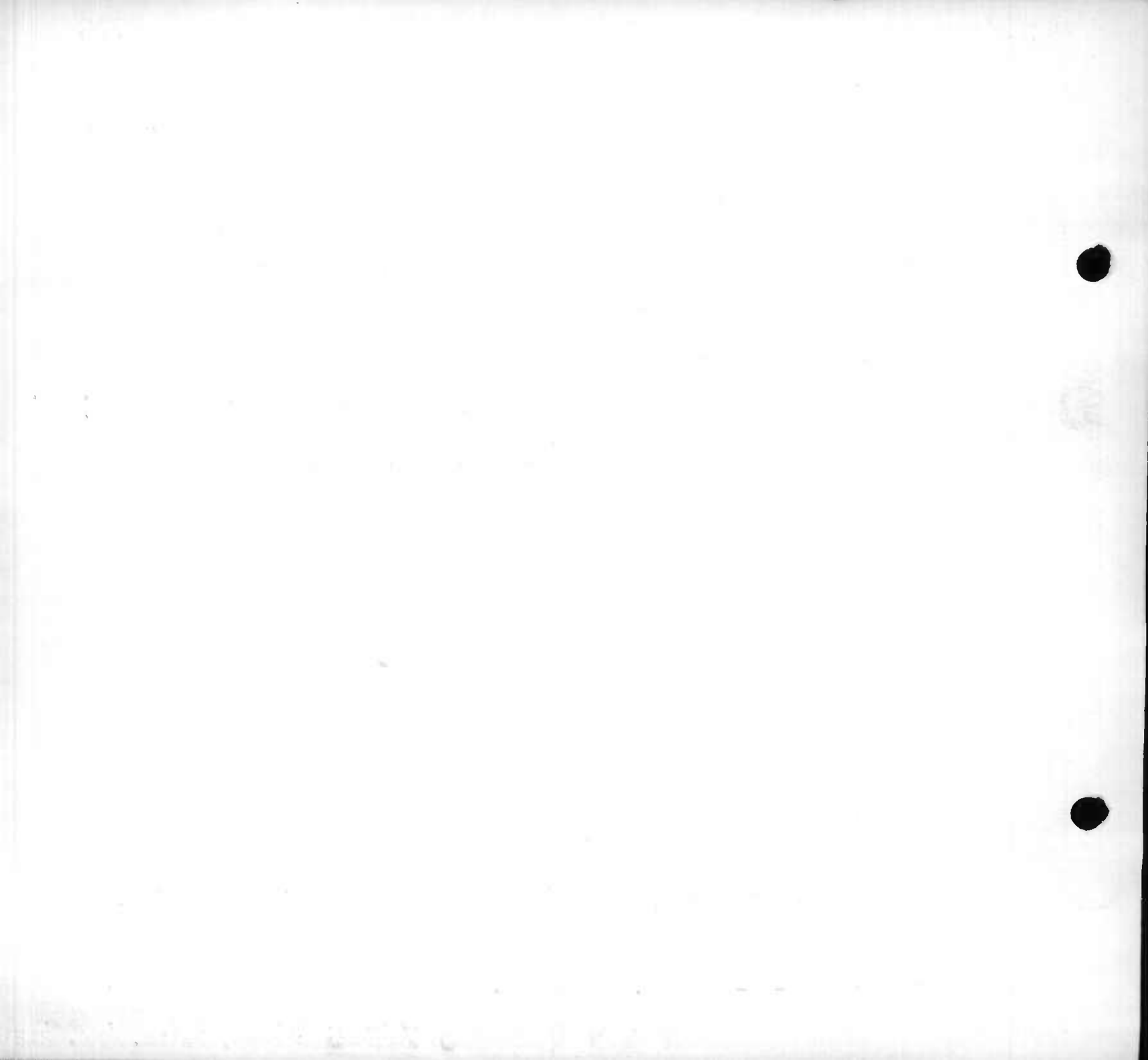
69 0776

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

69 0776

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Lula Davidson</u>		2. DATE AND HOUR OF DEATH <u>1/19/69</u> <u>8<sup>00</sup> P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hospital</u>			A. STATE <u>MD</u> B. COUNTY <u>15-12</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Balto</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>2934 Druid Park Drive</u>		
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-20-24</u>	9. AGE (in years last birthday) <u>44</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>THOMAS WILKES</u>			14. MOTHER'S MAIDEN NAME <u>ALELAIDE WILKES</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Raymond Davidson</u>	
18. <u>174X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of Breast = metastases to liver &amp; lungs</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>3 years</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>1/16</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Teen) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1/16</u> 19 <u>69</u> to <u>1/19</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>1/19</u> 19 <u>69</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Stanford H. Mahoney MD</u>				23B. DATE SIGNED <u>1/19/69</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					
24B. DATE <u>1-26-69</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Moriah Ch. Cem</u>		24D. LOCATION (City, town, or county) (State) <u>Chester, South Carolina</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 22 1969</u>		25B. NAME OF REGISTRAR <u>John E. Johnson</u>		25C. FUNERAL DIRECTOR <u>MORTON &amp; DYETT FUNERAL HOMES, INC.</u>	
25D. ADDRESS <u>1701 Laurens Street, Balto., Md. 21217</u>					



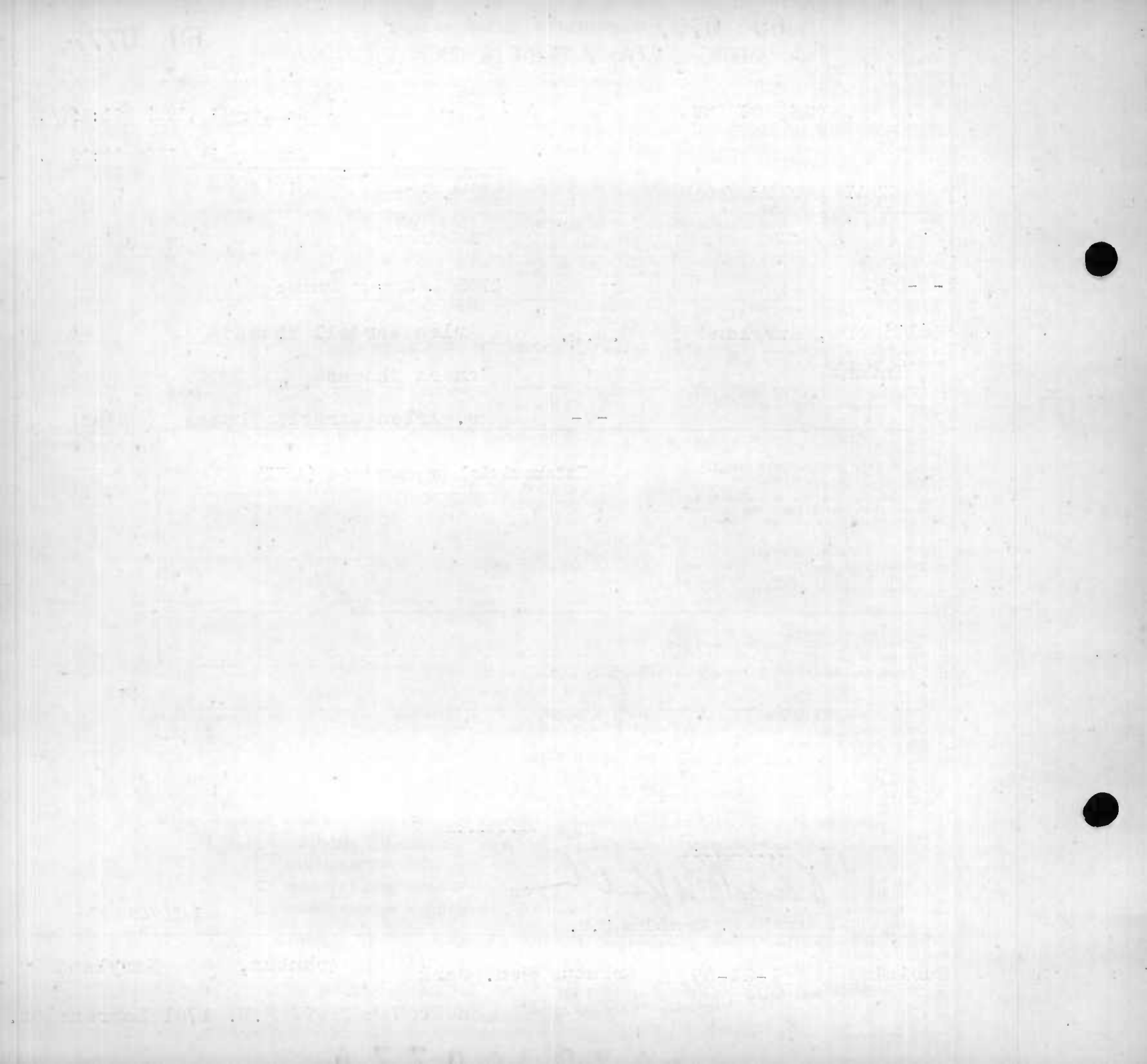
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 0777

BIRTH NO. 69-00071

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>THOMAS WHITNEY</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>January 19, 1969</b> <b>11:15 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 19, 1969 11:15 A.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>1-2-69</b>		10. AGE (In years lost birthday) <b>17</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Arlen Wardell Thomas</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>	
15. MOTHER'S MAIDEN NAME <b>Sandra Thomas</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>-0-</b>		18. INFORMANT <b>Mr. Arlen Wardell Thomas</b>	
19. CAUSE OF DEATH <b>484 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Interstitial pneumonitis (SDII)</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Same</b>		20. DATE OF OPERATION <b>2</b>	
21. AUTOPSY? (Yes or No) <b>yes</b>		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22C. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		22D. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22E. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED	
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		1/20/69	
ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	
24B. DATE <b>1-21-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Arbutus, Maryland</b>		25A. DATE RECEIVED BY HEALTH DEPT. <b>1-21-69</b>	
25B. NAME OF REGISTRAR <b>Robert C. [Signature]</b>		25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>	
ADDRESS <b>1701 Laurens St.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

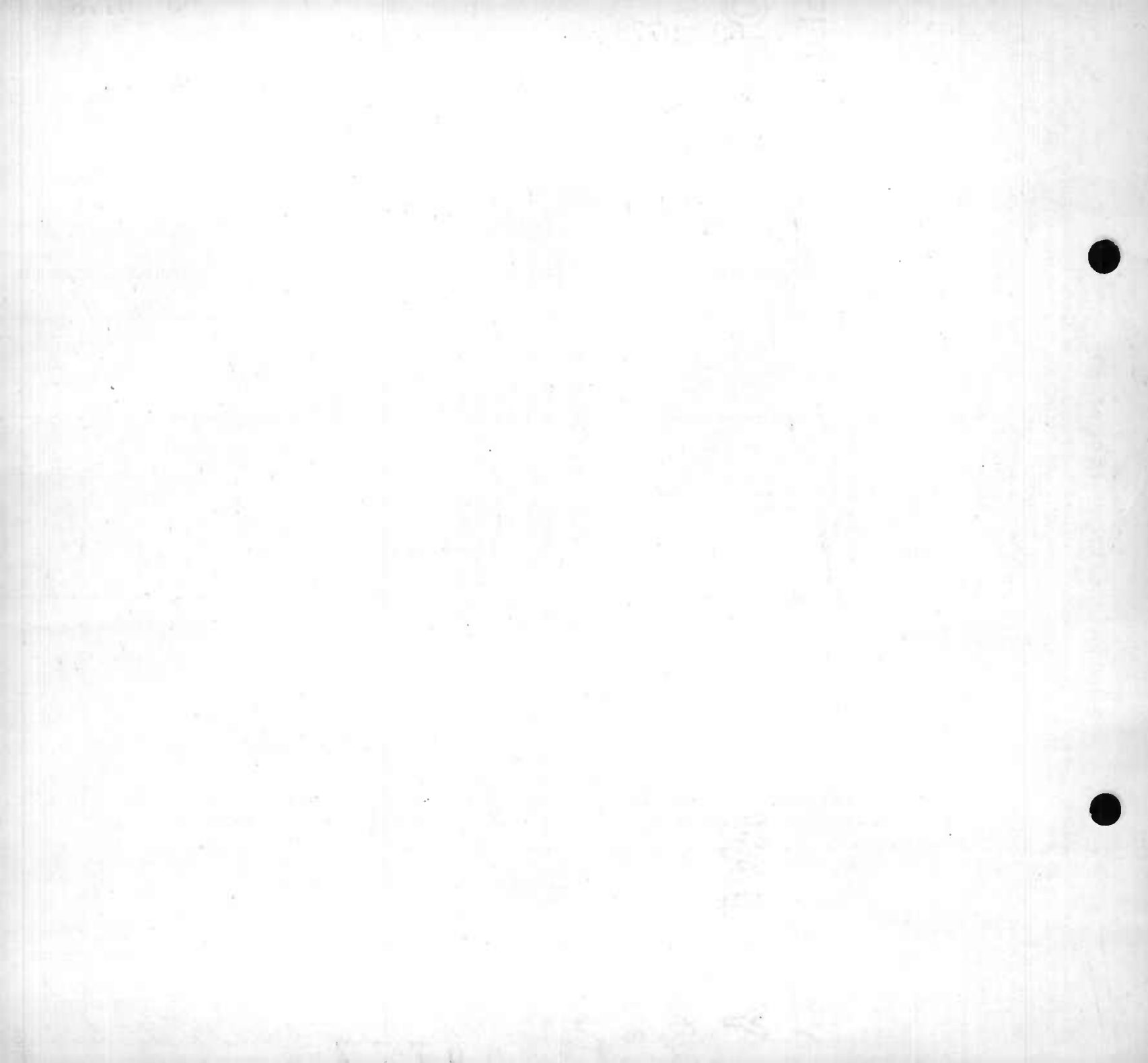
## 69 0778 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

69 0778

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Hattie Marie Kanungo</i>		2. DATE AND HOUR OF DEATH <i>January 16, 1969</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>20-37</i>		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <i>002547 W. Baltimore St.</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i>	
		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <i>3011 Baltimore St.</i>	
5. SEX <i>Female</i>	6. RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 10-1892</i>	9. AGE (In years last birthday) <i>76</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>James Hawkins</i>	
18. <i>401X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Atherosclerosis, generalized</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 1/2 years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>High blood pressure</i>				<i>3 1/2 years.</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>March 1, 1965</i> to <i>Jan. 16, 1969</i> , that (I) <del>lost</del> <i>lost</i> saw the deceased alive on <i>Dec. 24, 1965</i> and that in (my) <del>my</del> <i>my</i> opinion death occurred on the date and hour and from the causes stated above. (I) <del>we</del> <i>we</i> (did not) view the body after death.					
23A. SIGNATURE <i>Gilbert E. Rudman, M.D.</i>				23B. DATE SIGNED <i>1/21/69</i>	
23C. PHYSICIAN'S NAME (Type) <i>GILBERT E. RUDMAN, M.D.</i>				23D. ADDRESS <i>2517 W. Baltimore St.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1- -69</i>		24C. NAME OF CEMETERY or CREMATORY <i>McHaleys Cat</i>	
24D. LOCATION (City, town, or county) (State) <i>002547 W. Baltimore St.</i>		24E. DATE REC'D BY HEALTH DEPT. <i>JAN 22 1969</i>		24F. NAME OF REGISTRAR <i>Robert E. Johnson</i>	
24G. FUNERAL DIRECTOR <i>Chapman on Brantley</i>		24H. ADDRESS			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 0779

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

STEVEN G. WOMACK

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

9:30 a. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

D.O.A.

Maryland General Hospital

3. DATE  
PRONOUNCED DEAD

January 12, 1969

9:30 a. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

Sept. 26, 1919

10. AGE (In years  
last birthday)

48

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

21 W. Preston St.

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Florey Womack

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Truck Driver

14B. KIND OF BUSINESS OR INDUSTRY

A.S. Abell Co

15. MOTHER'S MAIDEN NAME

Ada White

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give year or dates of service)

Yes World War II

17. SOCIAL  
SECURITY NO.

231-18-8681

18. INFORMANT

Steven G. Womack

ADDRESS

19.

486X-137-9

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Pneumonia  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

Garcinoma of the stomach

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Partial

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ P Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

Edward F. Wilson, M.D.

EXAMINER'S  
NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/13/69

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1/15/69

24C. NAME OF CEMETERY or CREMATORY

Preston Cem.

24D. LOCATION (City, town, or county)

Lynchburg, Va.

25A. DATE RECEIVED BY HEALTH DEPT.

JAN 14 1969

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Wm J. Tichner Sons Balto Md.

ADDRESS

0770 81

10:11

10:11

10:11

10:11

✓

X

Virginia U.S.A. Flower the mark  
Truck driver A. Stolle the white  
Yes weather II 21-12-1911 Street C. the mark

Document of the station

WALTER HOBBS

WALTER HOBBS

11/11/1911 Virginia Gen. Highway, Va.  
11/11/1911 Virginia Gen. Highway, Va.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 0780

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JAMES SCHECKELS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>January 5, 1969</b> Hour <b>12:30 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>MERCY HOSPITAL (DOA)</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year <b>January 5, 1969</b> Hour <b>12:30 A.M.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>18-03</b>			
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH <b>4-18-1906</b>		10. AGE (In years lost birthday) <b>62</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Handyman</b>		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME <b>Lillian M. Edmondson</b>		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>218-10-7570</b>	
18. INFORMANT <b>Lillian Penn</b>		ADDRESS <b>3515 Meadowside Rd.</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> DATE SIGNED <b>1/5/69</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/18/69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Md</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>JAN 22 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>	
25C. FUNERAL DIRECTOR <b>Wm. J. Tichner &amp; Sons</b>		ADDRESS <b>Baltimore, Md.</b>	

John Charles Schmitt

Wm. Edwards

2018-01-25 11:11 AM - 2018-01-25 11:11 AM

Kindly refer back to the above, etc.

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0781

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

REG. NO.

69 0781

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MARY BELL BROWN</b>		2. DATE AND HOUR OF DEATH <b>1/21/69</b> <b>4<sup>20</sup> A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>UNIV. OF MD HOSP.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>18-01</b>		C. CITY OR TOWN <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>38 BALTO. MD</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>F</b>		6. RACE <b>N</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H/W</b>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>4/21/10</b>	
13. FATHER'S NAME <b>RALPH JOHNSON</b>		14. MOTHER'S MAIDEN NAME <b>MARY B. PARKER</b>		9. AGE (In years last birthday) <b>58</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) <b>Va.</b>	
17. INFORMANT <b>Chart</b>		ADDRESS		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
18. <b>712.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive Arteriosclerotic Cardio-vascular Disease</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Chronic Renal Disease - End-stage</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Chronic Renal Disease - End-stage</b>			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Huntington's Chorea</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8-28-</b> <b>1962</b> to <b>1-21</b> <b>1969</b> that (I) <del>was</del> last saw the deceased alive on <b>1/21/69</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>Yes</del> (did) <del>view</del> (did not) view the body after death.					
23A. SIGNATURE <b>Larry L. Wilkins MD</b>		23B. DATE SIGNED <b>4/21/69</b>		23C. PHYSICIAN'S NAME (Type) <b>DEGREE</b>	
23D. ADDRESS		23E. DEGREE		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/24/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>MT Auburn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 22 1969</b>		25B. NAME OF REGISTRAR <b>Robert J. Johnson</b>	
25C. FUNERAL DIRECTOR <b>I Carroll Halstead Funeral Home</b>		25D. ADDRESS		25E. ADDRESS	

100-100000  
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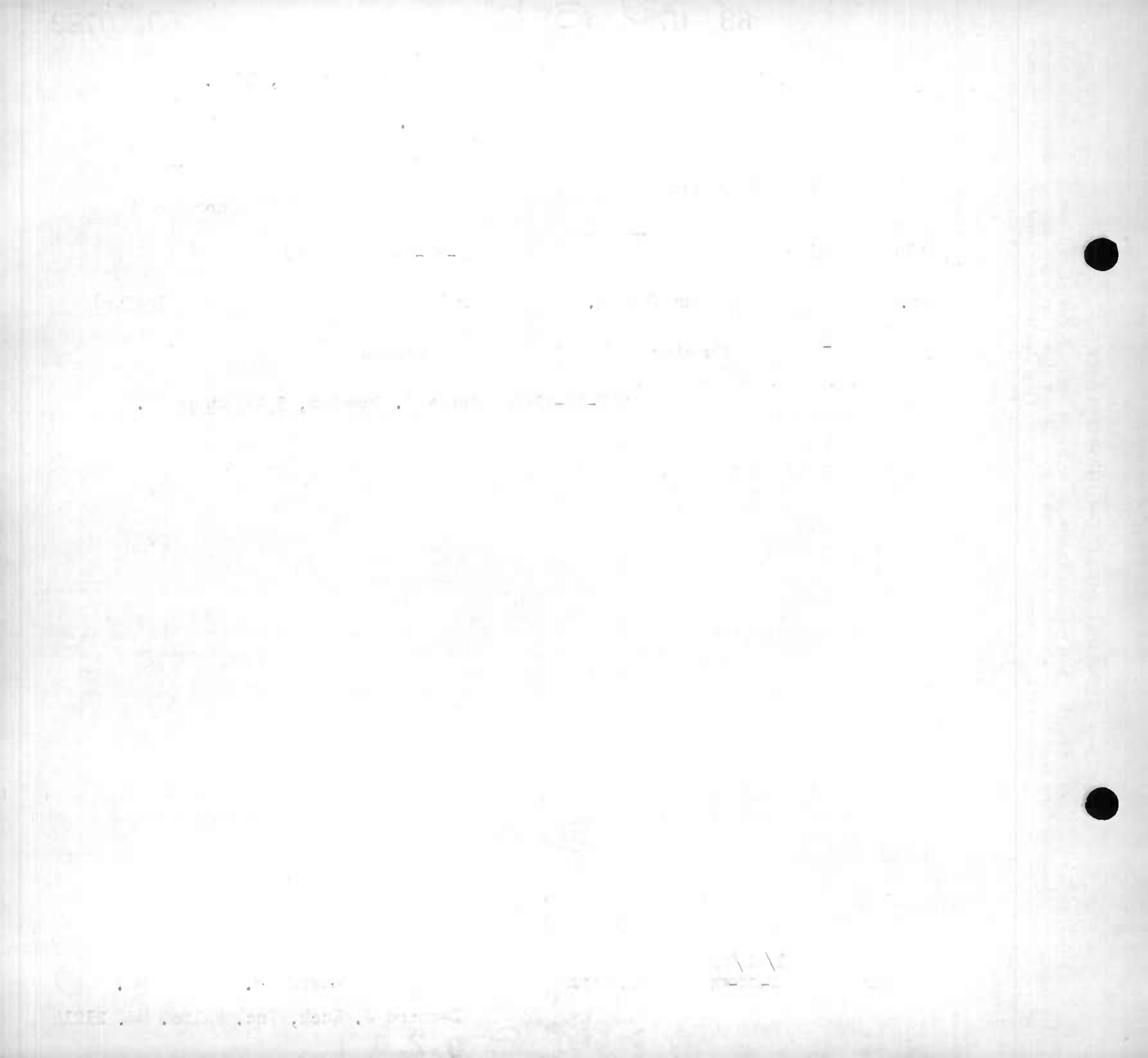
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0782

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 0782

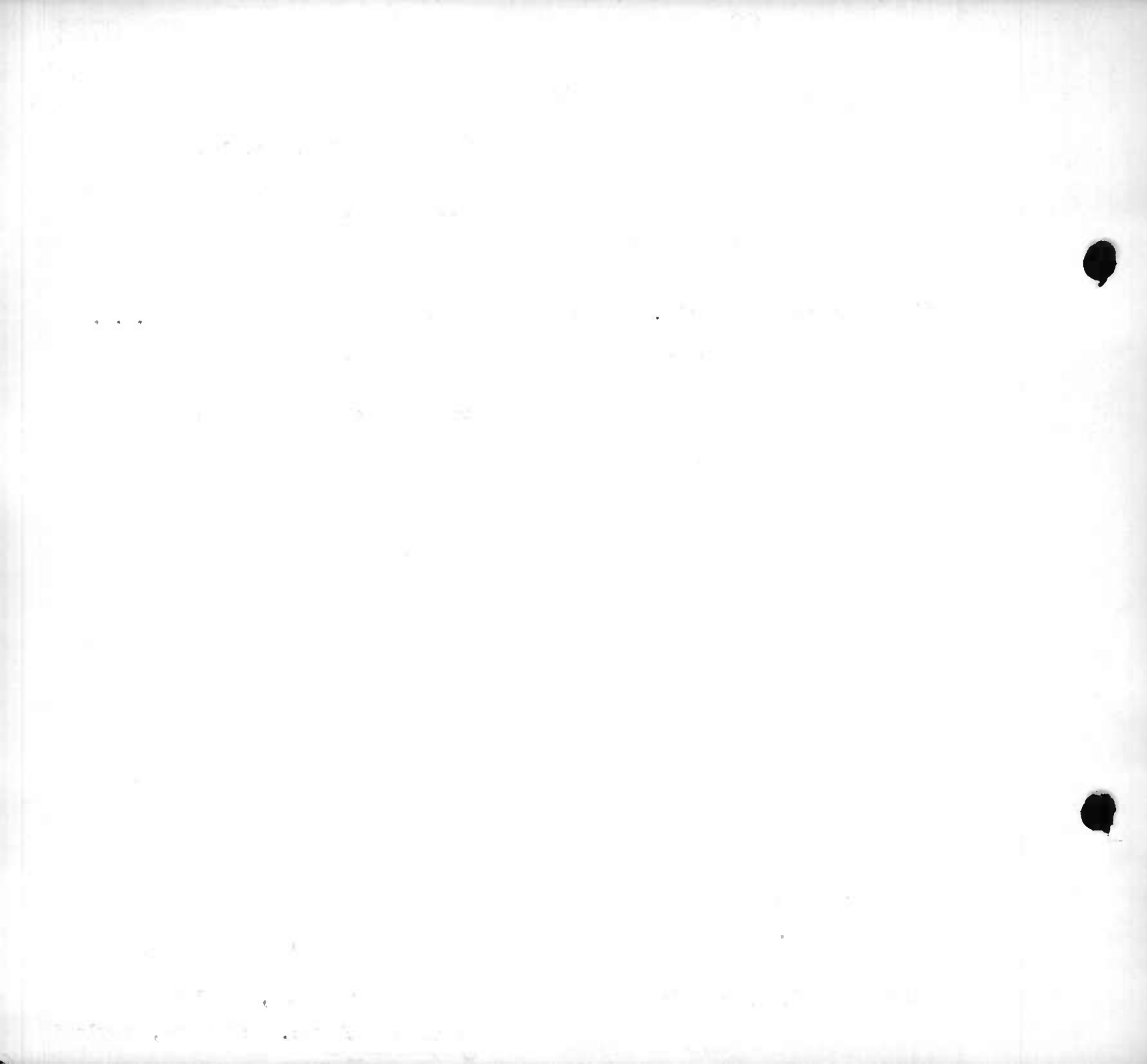
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JOHN PETER CUMMINS		January 19, 1969.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE Md.	
00 3621 Ednor Road				B. COUNTY	
				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3621 Ednor Road	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-21-99	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Ret.		Sun Oil Co.		Ireland	
12. CITIZEN OF WHAT COUNTRY? Ireland			13. FATHER'S NAME Cummins		
14. MOTHER'S MAIDEN NAME Unknown			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 215-18-7363			17. INFORMANT Annie J. Cummins, 3621 Ednor Rd.		
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE Pulmonary hemorrhage		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Carcinoma of lung		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			(C)		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 1968 to Jan 18 1969, that (I) (we) last saw the deceased alive on Jan 18 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Richard F. Ruck				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) C. Richard F. Ruck				23D. ADDRESS 705 Med Arts Bldg, Baltimore Md 21201	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/22/69		24C. NAME OF CEMETERY or CREMATORY Crestlawn	
24D. LOCATION (City, town, or county) Howard Co.		24E. STATE Md.		24F. ADDRESS	
25A. DATE REC'D BY HEALTH DEPT. JAN 22 1969		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21211	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0783		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 0783	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>VITALE Joseph A Sr</u>		2. DATE AND HOUR OF DEATH <u>1/21/69</u> <u>7 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Balto Co</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore Md 21234</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		53-00	
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 The Johns Hopkins Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>2833 Cub Hill Rd</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-8-96</u>	9. AGE (In years last birthday) <u>72</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Foreman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Balt. City Water Dept</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>PASQUALE Vitale</u>		14. MOTHER'S MAIDEN NAME <u>CONCETTA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217 24 7781</u>		17. INFORMANT <u>Frances Vitale</u> ADDRESS <u>Same</u>	
18. <u>4-31-9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Recurrent Intracerebral Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>ATHEROSCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>PNEUMONIA</u> <u>RENAL FAILURE</u> <u>POSS PULMONARY EMBOLISM</u>				<u>2 days</u> <u>8 days</u>	
19A. DATE OF OPERATION <u>1-14-69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>INTRACEREBRAL HEMATOMA</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Jaundice</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>December 9</u> 19 <u>69</u> to <u>January 21</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>January 21</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>F. Velasco</u>		DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1-21-69</u>	
23C. PHYSICIAN'S NAME (Type) <u>F. VELASCO</u>		23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/25/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 22 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. [unclear]</u>		25C. FUNERAL DIRECTOR <u>Leonard J Ruck Inc.</u> ADDRESS <u>Baltimore, Maryland</u>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.
1. NAME OF DECEASED (Type or Print) <b>TENNANT, DELLA</b>		2. DATE AND HOUR OF DEATH <b>1/21/69 7:20 A</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>90</b>		A. STATE <b>Maryland</b> B. COUNTY <b>9-01</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>House in the Pines Del Ave 2837 Belair Road Baltimore Md. 21206</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>3911 Ednor Rd</b>				
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/18/1898</b>	9. AGE (In years last birthday) <b>70</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Federal Employee</b>		11. BIRTHPLACE (State or foreign country) <b>Nebraska</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>E. Frank Smith</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Chumb</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <b>No</b>		16. SOCIAL SECURITY NO. <b>219-42-1735</b>		17. INFORMANT <b>Carole Tennant</b>
				ADDRESS <b>Same</b>
18. <b>203X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Multiple Myeloma</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 mos</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Multiple Myeloma</b>		
		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Chronic Arteriosclerosis Multiple Sclerosis</b>		<b>5 years</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>7/28/1968</b> to <b>1/21/1969</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>1/15/1969</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.				
23A. SIGNATURE <b>Albert B. Bradley</b>		23B. DATE SIGNED <b>1/21/69</b>		
23C. PHYSICIAN'S NAME (Type) <b>Albert B. Bradley M.D.</b>		23D. ADDRESS <b>4900 Belair Rd. Balto. Md.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/24/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arlington National</b>
24D. LOCATION <b>Arlington, Virginia</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 22 1969</b>		25B. NAME OF REGISTRAR <b>Robert G. Taylor</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc</b>
				ADDRESS <b>Baltimore, Maryland</b>

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Handwritten notes in the lower section of the page.

Handwritten notes at the bottom of the page.

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 69 0785 CERTIFICATE OF DEATH

REG. NO. 69 0785

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Calvert, Julia V.</i>		2. DATE AND HOUR OF DEATH <i>JAN 20, 1969</i>   <i>7 P</i> M.													
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>9-01</i>														
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bolton Hill Nursing Center</i>			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												
5. SEX <i>F</i>		6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-26-79</i>	9. AGE (In years lost birthday) <i>89</i>												
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Nurse</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>													
13. FATHER'S NAME <i>Edward Viol</i>			14. MOTHER'S MAIDEN NAME <i>Eleanor Belchner</i>														
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-32-2998</i>		17. INFORMANT <i>Charlotte Kenning</i>													
				ADDRESS <i>Same</i>													
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="4"> <b>1B. CAUSE OF DEATH</b>  <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p><b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)</p> <p><i>4/12/3</i></p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 35%;"> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pneumonia</i></p> <p>(B) <i>arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) <i>arteriosclerosis generalized</i></p> </div> </div> </td> <td colspan="2"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs.</i></p> </td> </tr> <tr> <td colspan="4"> <p><b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p> </td> <td colspan="2"></td> </tr> </table>						<b>1B. CAUSE OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p><b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)</p> <p><i>4/12/3</i></p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 35%;"> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pneumonia</i></p> <p>(B) <i>arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) <i>arteriosclerosis generalized</i></p> </div> </div>				<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs.</i></p>		<p><b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
<b>1B. CAUSE OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p><b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)</p> <p><i>4/12/3</i></p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 35%;"> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pneumonia</i></p> <p>(B) <i>arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) <i>arteriosclerosis generalized</i></p> </div> </div>				<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs.</i></p>													
<p><b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>																	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)													
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)													
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?													
22. I certify that (I) (this hospital) attended the deceased from <i>1/9</i> 19 <i>69</i> to <i>1/20</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>1/20</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																	
23A. SIGNATURE <i>ALLAN H. MACHT MD</i>				23B. DATE SIGNED <i>1/20/69</i>													
23C. PHYSICIAN'S NAME (Type) <i>ALLAN H. MACHT MD</i>				23D. ADDRESS <i>2 E. READ ST. BAL MD 21202</i>													
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/24/69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Loudon Park</i>													
24D. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>																	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 22 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Finkbeiner</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc.</i>													
				ADDRESS <i>Balto. Md.</i>													

Small House

Small House

Small House

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Small House

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
69 0786 CERTIFICATE OF DEATH

REG. NO. 69 0786

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		SUSIE I. PITTMAN		January 21, 1969. 7 <sup>30</sup> A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 00 5933 Glenkirk Road				A. STATE Md. B. COUNTY 27-48	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 5933 Glenkirk Road	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct. 8, 1884.	84	USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Virginia	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John Pritchett			Nonie Carter		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		215-09-3869D		Mrs. Nona I. Brown (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
I 4-92 X I CAUSE OF DEATH caused by heart failure				2 weeks	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
(B) EMPHYSEMA DUE TO, OR AS A CONSEQUENCE OF:				10 years	
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec 27 67 to present 19 68, that (I) (we) last saw the deceased alive on July 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Frankers x Carmody				23B. DATE SIGNED 1-21-69	
23C. PHYSICIAN'S NAME (Type) FRANKERS x Carmody				23D. ADDRESS 3201 N Charles	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		1/23/69.		Western Cemetery	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 22 1969		Robert S. Jenkins		Leonard J. Buck, Inc. Balto. Md. 21214	



FUNERAL DIRECTOR: IMPORTANT

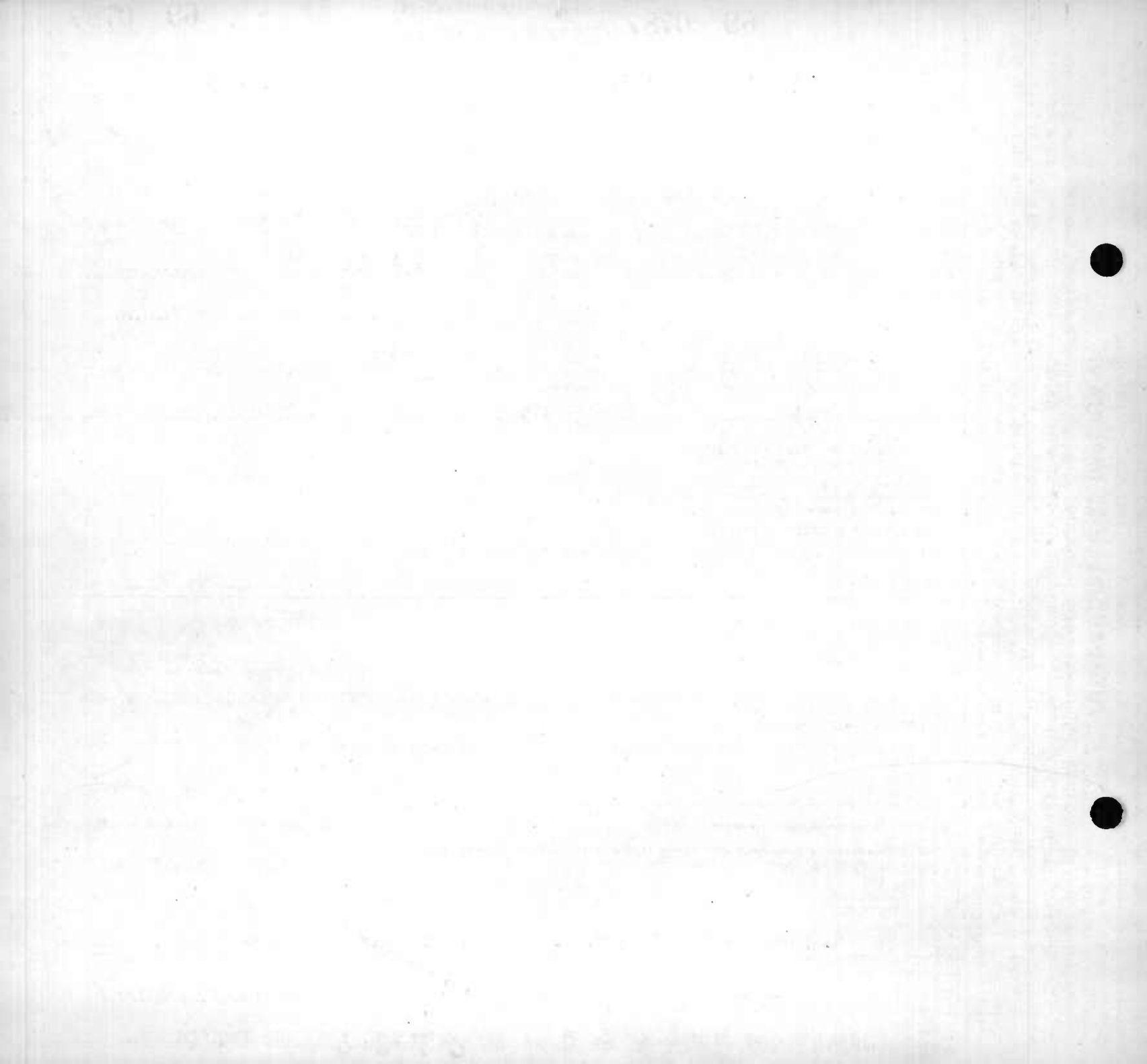
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 69 0787 CERTIFICATE OF DEATH

REG. NO. 69 0787

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		HERBERT THOMAS GREEN		JANUARY 18, 1969 8:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 2505 BROOKFIELD AVENUE				A. STATE MARYLAND	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY	
				C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2508 BROOKFIELD AVENUE	
5. SEX MALE	6. RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 28, 1911	9. AGE (In years last birthday) 58	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME LOUIS F. GREEN		14. MOTHER'S MAIDEN NAME MARY SIMPSON		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 218-07-0174		17. INFORMANT LILLIAN GREEN - 2508 BROOKFIELD AVE.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo	
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Degeneration	
				(B) Anterior Degeneration of Spine	
				(C)	
19A. DATE OF OPERATION					
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-20-69 to 1-18-69, that (I) (we) last saw the deceased alive on 1-18-69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE G. Franklin Phillips, M.D.				23B. DATE SIGNED 1/20/69	
23C. PHYSICIAN'S NAME (Type) G. FRANKLIN PHILLIPS, M. D.				23D. ADDRESS 558 MEACHEM STREET, BALTIMORE, MARYLAND	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1-22-69		24C. NAME OF CEMETERY or CREMATORY BALTIMORE NATIONAL	
24D. LOCATION BALTIMORE, MARYLAND		24E. NAME OF REGISTRAR CHARLES R. LAW		24F. FUNERAL DIRECTOR ADDRESS 802 MADISON AVE.	
25A. DATE REC'D BY HEALTH DEPT. JAN 22 1969		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	

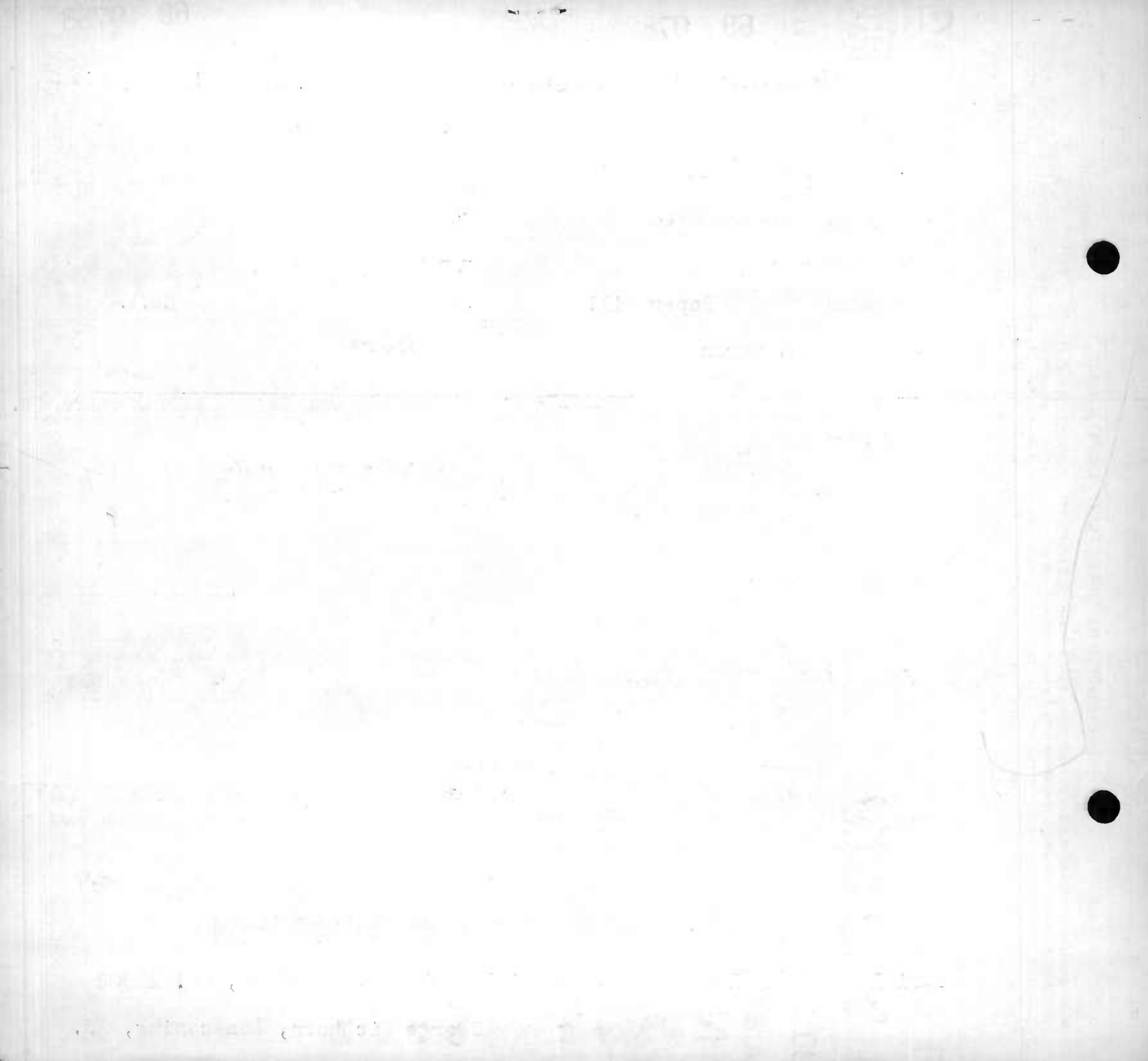






This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

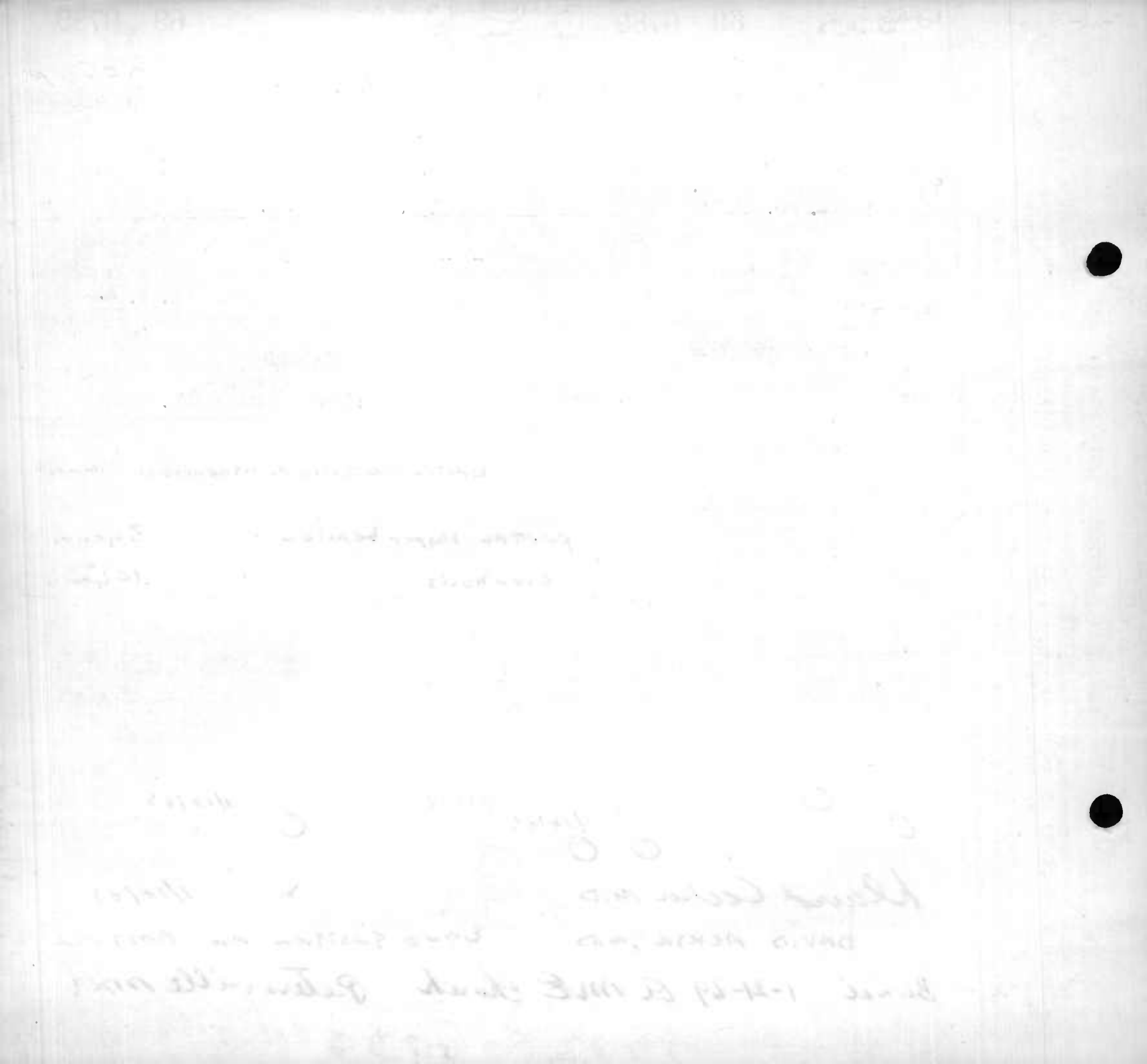
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="float: right;">69 0788</span>	
BIRTH NO. <span style="float: right;">C-565</span>		69 0788	
1. NAME OF DECEASED (Type or Print) <b>William J. Cameron</b>		2. DATE AND HOUR OF DEATH <b>20 JANUARY 1969 12:25 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE</b> <b>BALTIMORE, MARYLAND 21224</b>		A. STATE <b>MD.</b> B. COUNTY <b>ALLEGANY</b> <span style="float: right;">51-00</span>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>LONA CONING</b>	
		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <b>24 ISLAND STREET</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-3-31</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TOURMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Paper Mill</b>	9. AGE (In years last birthday) <b>37</b>
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ARCH Cameron</b>		14. MOTHER'S MAIDEN NAME <b>EDNA STAUP</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>220-28-96900</b>	
		17. INFORMANT <b>BCH RECORDS 4940 EASTERN AVENUE, BALTO. MD.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>SARCOMA-METASTATIC TO LUNGS (1<sup>st</sup> ORBIT)</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 YR</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <b>FEB. 1968</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>SARCOMA ORBIT</b>	
20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Home <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <b>4 JAN. 1969</b> to <b>20 JAN. 1969</b> , that (I) <del>last</del> saw the deceased alive on <b>20 JAN. 1969</b> and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did</del> (did not) view the body after death.			
23A. SIGNATURE <b>Russell D Hicks MD</b>		23B. DATE SIGNED <b>20 JAN 1969</b>	
23C. PHYSICIAN'S NAME <b>RUSSELL HICKS, MD.</b>		23D. ADDRESS <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE 21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/23/1969</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Sunset Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Cumberland, Md. 21502</b>	
25A. DATE RECEIVED BY HEALTH DEPT <b>1-23-69</b>		25B. NAME OF REGISTRAR <b>Robert E. Salyers</b>	
25C. FUNERAL DIRECTOR <b>George Eichhorn</b>		ADDRESS <b>Lonaconing, Md.</b>	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-523		69 0789		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 0789	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Virginia L. Winston</i>			
2. DATE AND HOUR OF DEATH <i>1/18/69</i>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>10-01</i>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>				5. SEX <b>FEMALE</b> 6. RACE <b>NEGRO</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVE.</b> <b>BALTO. MD. 21224</b>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <b>1051 N. CENTRAL AVE. 21205</b>				9. AGE (In years last birthday) <b>43</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>THEODORE SPRIGGS</b>				14. MOTHER'S MAIDEN NAME <b>HELEN PALMER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>unknown</b>			
17. INFORMANT <b>BCH RECORDS: 4940 EASTERN AVE. 21224</b>				ADDRESS			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>GASTRO-INTESTINAL HEMORRHAGE</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>PORTAL HYPERTENSION</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>CIRRHOSIS</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immed</b> <b>3 years</b> <b>10 years</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>1/18/69</b> 19 to <b>1/18/69</b> 19 that (1) (we) last saw the deceased alive on <b>1/18/69</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>David Ackers M.D.</i>				23B. DATE SIGNED <b>1/18/69</b>		23C. PHYSICIAN'S NAME (Type) <b>DAVID ACKERS, M.D.</b>	
23D. ADDRESS <b>BALTIMORE CITY HOSPITALS 21224</b> <b>4940 EASTERN AVE BALTO MD</b>		23E. ADDRESS <b>BALTIMORE CITY HOSPITALS 21224</b> <b>4940 EASTERN AVE BALTO MD</b>		23F. ADDRESS <b>BALTIMORE CITY HOSPITALS 21224</b> <b>4940 EASTERN AVE BALTO MD</b>		23G. ADDRESS <b>BALTIMORE CITY HOSPITALS 21224</b> <b>4940 EASTERN AVE BALTO MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-21-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>AME Church</b>		24D. LOCATION (City, town, or county) (State) <b>Petersville md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 22 1969</b>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>John J. Brunowick - Md.</i>		25D. ADDRESS <b>BALTIMORE CITY HOSPITALS 21224</b> <b>4940 EASTERN AVE BALTO MD</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 0790

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>WILLIAM MARKELL, JR.</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input checked="" type="checkbox"/> January 21, 1969 2:00 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore General Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour January 21, 1969 8:08 A.M.	
6. SEX <b>male</b>	7. RACE <b>white</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>BALTIMORE</b>
9. DATE OF BIRTH <b>11/5/68</b>	10. AGE (In years last birthday) <b>2 1/2 Mo.</b>	11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	13. FATHER'S NAME <b>WILLIAM F. MARKELL SR.</b>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		17. SOCIAL SECURITY NO. <b>*****</b>	15. MOTHER'S MAIDEN NAME <b>LINDA WARD</b>
19. <b>457 X 1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Interstitial Pneumonitis (SDII)</b>		18. INFORMANT <b>WM. F. MARKELL, 1507 JACKSON ST., BALTIMORE</b>	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: <i>Russell S. Fisher</i> M.D. EXAMINER'S NAME (Type): <b>Russell S. Fisher, M.D.</b> DATE SIGNED: <b>1/21/69</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>1/23/68</b>	24C. NAME OF CEMETERY or CREMATORY <b>MEADOWRIDGE CEMETERY</b>	24D. LOCATION (City, town, or county) (State) <b>DORSEY, MARYLAND</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 22 1969</b>	25B. NAME OF REGISTRAR <i>R. E. Fisher</i>	25C. FUNERAL DIRECTOR <i>McCully</i>	ADDRESS <b>130 E. Fort Ave. Baltimore</b>

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L-260

69 0791 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 0791

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>MARY V. LAZZARRO</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>January 21, 1969</b> 2:30 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 21, 1969</b> 3:00 A.M.	
6. SEX <b>female</b>		7. RACE <b>white</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>Separated</b>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>9/2/1945</b>		10. AGE (In years lost birthday) <b>23</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>212-44-5970</b>	
18. INFORMANT <b>Joseph A. Lazzaro Jr.</b>		ADDRESS <b>3813 Elmora Ave #21213</b>	
19. CAUSE OF DEATH <b>E816.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Multiple Fractures of facial bones and Ruptured Spleen</b> (A) IMMEDIATE CAUSE <del>XXXXXX XXXXXXXXXX</del> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Frankfort and Knell Avenues</b>		22F. HOW DID INJURY OCCUR? <b>driver of auto - collided with phone pole.</b>	
22D. TIME OF INJURY (APPROX.) <b>1/21/69 2:30 A.M.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>1/21/69</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/24/69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>St. Stanislaus Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbairn</b>	
25C. FUNERAL DIRECTOR <b>George A. Weber</b>		ADDRESS <b>705 South Ann Street</b>	

N 208,7090000790

1970 03

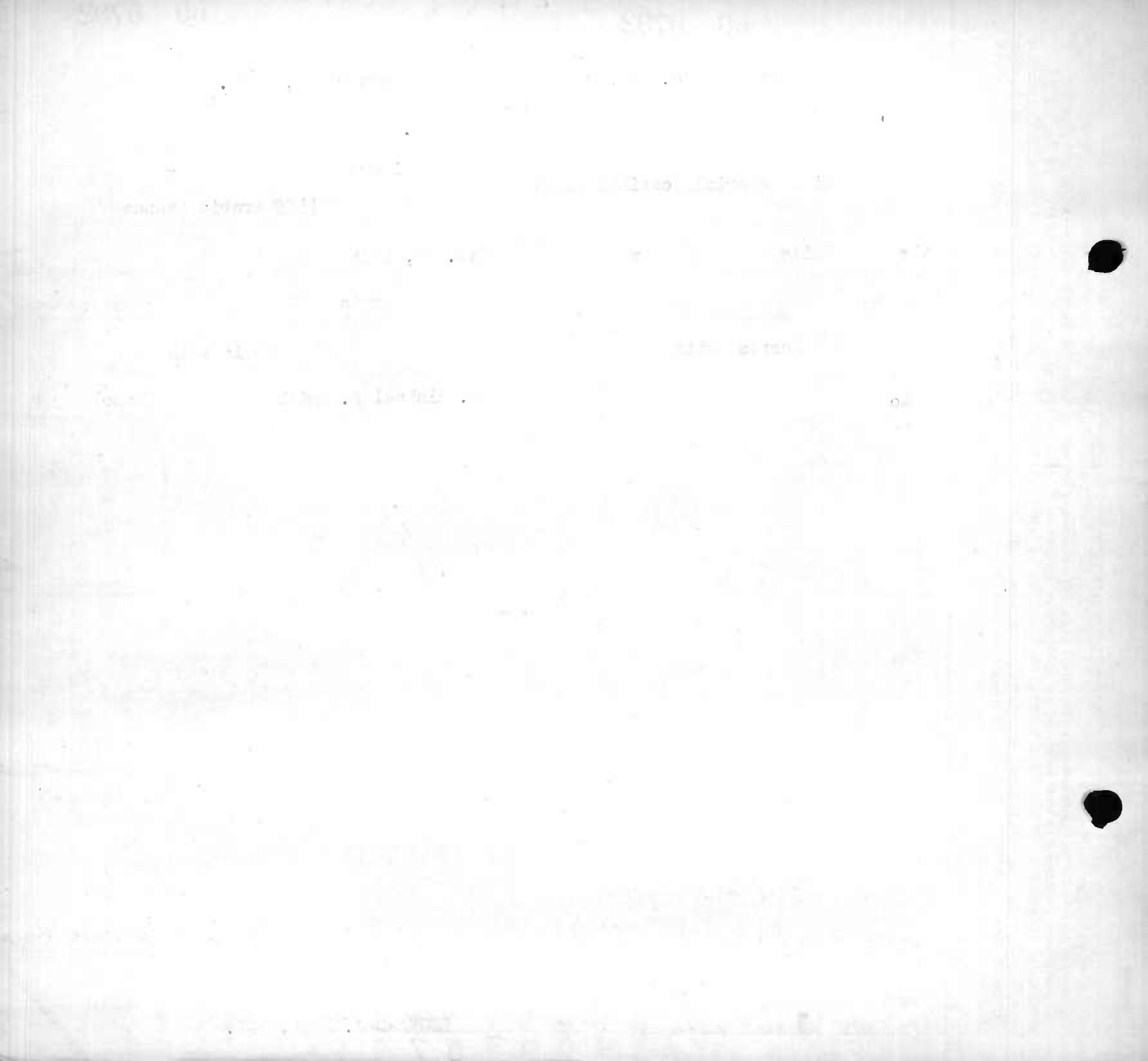
1970 03

WATKINS POLICE



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		SIGMOND J. SMITH		January 21, 1969.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 44 99 Union Memorial Hospital (DOA)				A. STATE Md. B. COUNTY 17-02	
5. SEX Male		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ad Man		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH Feb. 25, 1915	
13. FATHER'S NAME Morris Smith		14. MOTHER'S MAIDEN NAME Celia Volk		9. AGE (In years last birthday) 53	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) Georgia	
17. INFORMANT Mr. Michael L. Smith		ADDRESS (Same)		12. CITIZEN OF WHAT COUNTRY? USA	
18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE Coronary disease DUE TO, OR AS A CONSEQUENCE OF: (B) Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-3 yrs					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/9 1968 to 1/20 1969, that (I) (we) last saw the deceased alive on 11/25 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did not) view the body after death.					
23A. SIGNATURE Louis H. Schaffer, MD				23B. DATE SIGNED 1/21/69	
23C. PHYSICIAN'S NAME (Type) Louis H. Schaffer, M.D.				23D. ADDRESS 222 W Cold Spring Lane, Baltimore, Md 21206	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1/21/69		24C. NAME OF CEMETERY or CREMATORY JOHNS HOPKINS SCHOOL OF MEDICINE	
25A. DATE REC'D BY HEALTH DEPT. JAN 23 1969		25B. NAME OF REGISTRAR Robert E. Tarkenton		25C. FUNERAL DIRECTOR LEONARD J. RUCK, INC.	

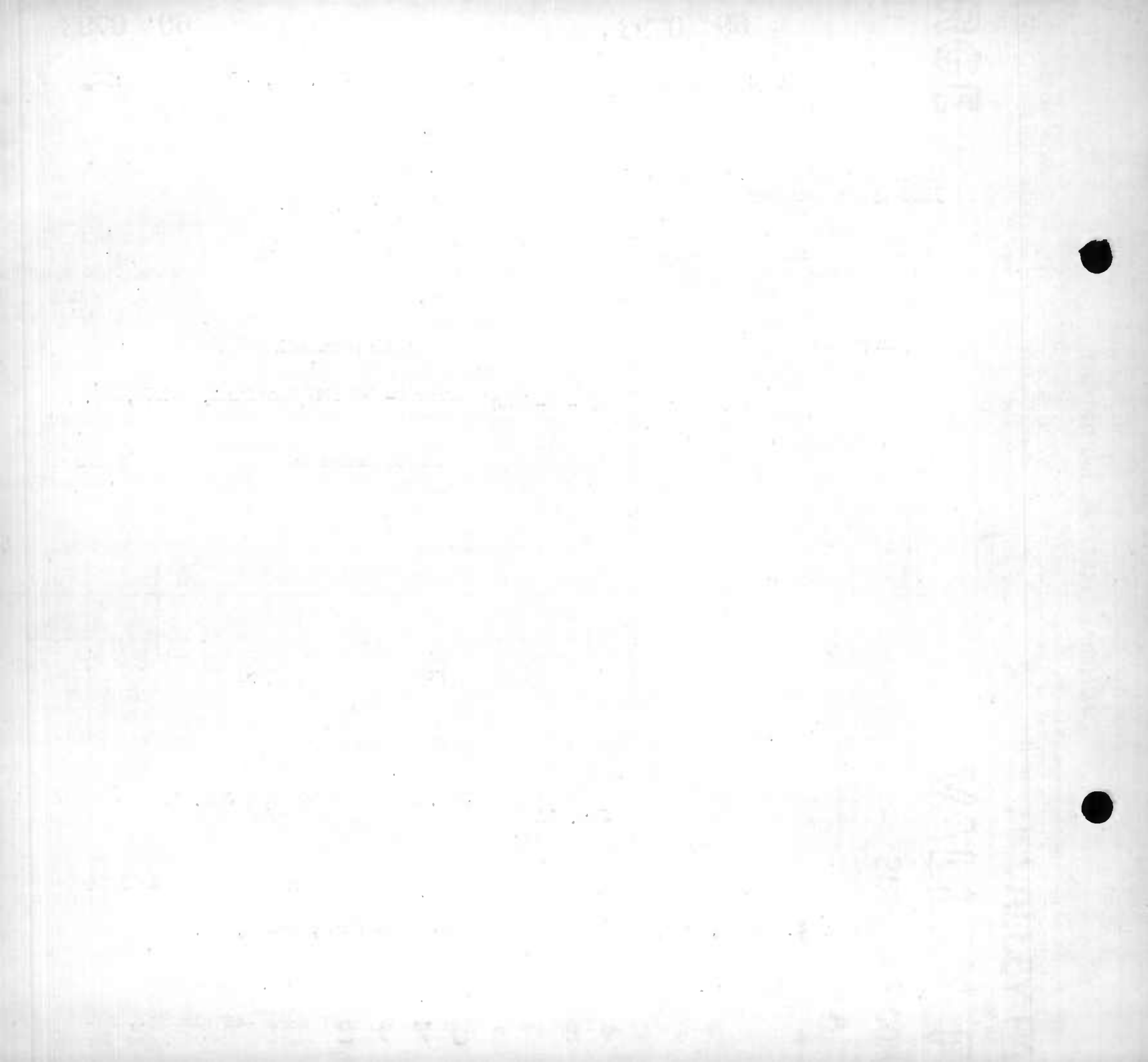


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
69 0793 CERTIFICATE OF DEATH X REG. NO. 69 0793

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Henry Cornelius Lee</b>		2. DATE AND HOUR OF DEATH <b>Jan. 21, 1969</b> <b>1:30</b> P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>NJ</b> B. COUNTY <b>V-27</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>US Public Health Service Hospital</b> <b>3100 Wyman Parkway</b>			C. CITY OR TOWN <b>Mt. Clear</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>12 Llewellyn Rd.</b>		
5. SEX <b>M</b>	6. RACE <b>col</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/21/07</b>	9. AGE (In years last birthday) <b>61</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>?</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Ga.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Henry Lee</b>		
14. MOTHER'S MAIDEN NAME <b>Sarah Marshall</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>136-10-9814</b>		17. INFORMANT ADDRESS <b>Records- US PHS Hospital, Balto, Md.</b>			
18. CAUSE OF DEATH <b>207.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Acute leukemia</b> <b>Weeks</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>(1)</b> (this hospital) attended the deceased from <b>Jan. 10 1969</b> to <b>Jan. 21 1969</b> , that <b>(1)</b> (we) lost saw the deceased alive on <b>Jan. 21 1969</b> and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(1)</b> (We) (did) <b>(did not)</b> view the body after death.					
23A. SIGNATURE <b>Henry S. Crist, MD</b>				23B. DATE SIGNED <b>1/21/69</b>	
23C. PHYSICIAN'S NAME (Typed) <b>Henry S. Crist, Surgeon (R)</b>				23D. ADDRESS <b>US PHS Hospital, Balto, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-25-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Heavenly Rest Mem. Park</b>	
24D. LOCATION <b>Hanover, New Jersey</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1969</b>			
25B. NAME OF REGISTRAR <b>Robert E. [illegible]</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Martin Funeral Home -48 Elm St., Mt. Clear, New Jersey</b>			



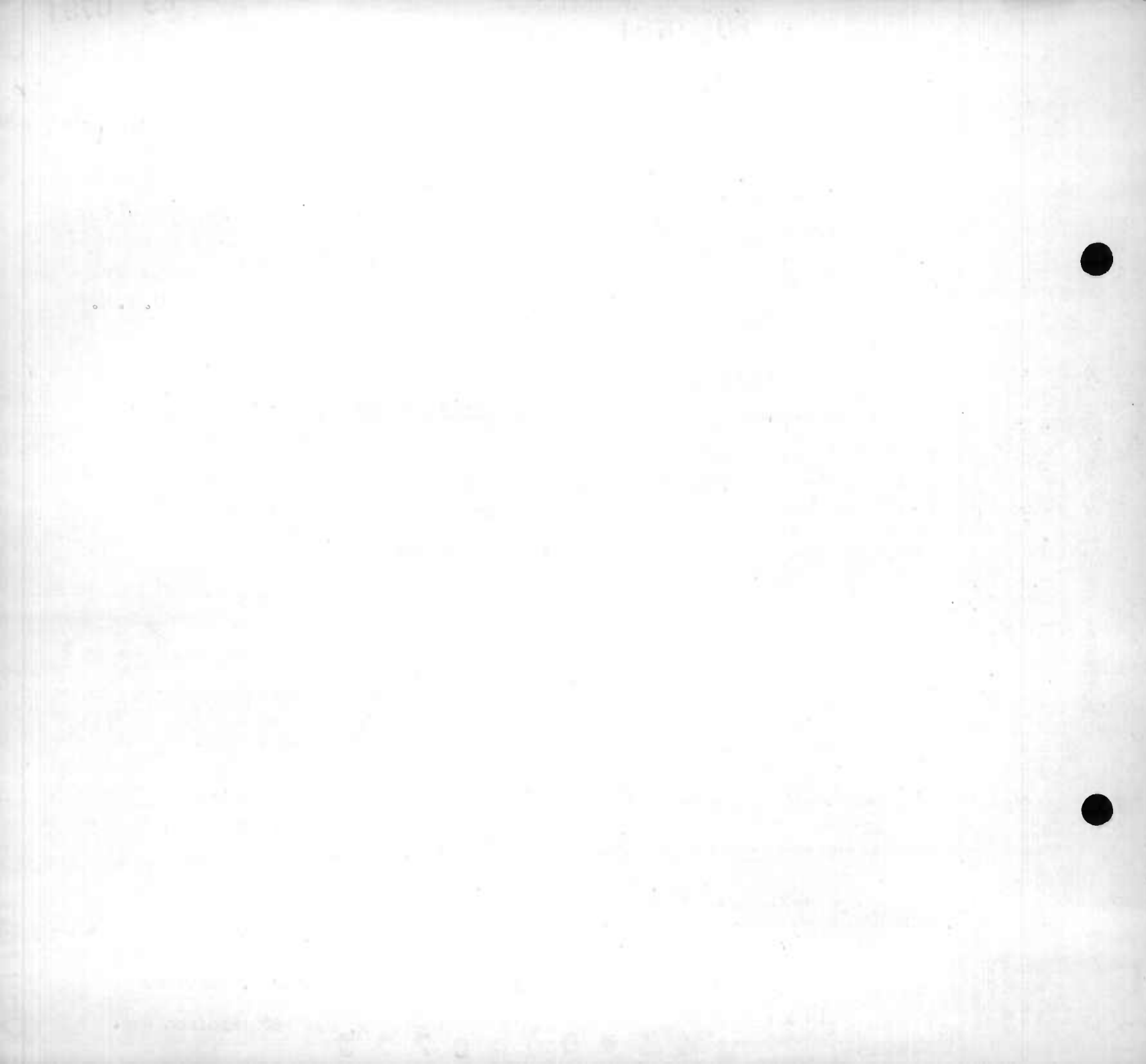
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 69 0794 CERTIFICATE OF DEATH

REG. NO. 69 0794

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Perry, Benjamin</u>		2. DATE AND HOUR OF DEATH <u>1-21-69</u> <u>2:45 p.m.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md.</u> B. COUNTY <u>15-02</u>		C. CITY OR TOWN <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>46 Lutheran Hosp. of Md.</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>		6. RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Sugar Refining</u>		8. DATE OF BIRTH <u>10-12-1903</u>	
11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		9. AGE (In years lost birthday) <u>65</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BENJAMIN PERRY</u>		14. MOTHER'S MAIDEN NAME <u>LUCINDY SHARP</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>212-09-5855</u>		17. INFORMANT <u>Elsie Perry - 1714 W. Presbury St.</u>		ADDRESS	
18. <u>436.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>C. U. A. &amp; (H.C.)</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-25</u> 19 <u>68</u> to <u>1-21</u> 19 <u>69</u> . that (I) (we) last saw the deceased alive on <u>2:45 p.m. 1-21</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>H. C. Park M.D.</u>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>Hyung Kyoun Park M.D.</u>	
23D. ADDRESS <u>730 Ashburton St. Balt.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>1-25-69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 23 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Charles R. Law</u>	
ADDRESS <u>802 Madison Ave.</u>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0795		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 0795	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BENHARDT F. BOLLACK		1-20-69 5:05P.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
920 S. BOULDIN ST.		MARYLAND		26-11	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		920 S. BOULDIN ST.			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. If Under 1 Yr. Months Days
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	3-7-1894	74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
SALESMAN		DAIRY		MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
PETER BOLLACK		ROSA COOK		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		214 01 8383		Mrs. Madeline Bollack - 920 S. Bouldin St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		2 Days	
ANTECEDENT CAUSES		(B) Arteriosclerotic Cardiovascular Disease		10 Yrs.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from March 19 49 to January 1969, that (I) (we) lost saw the deceased alive on Jan. 20 19 69 and that in (my) <del>four</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Clarence W. LeDoux				1/23/69	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Clarence W. LeDoux, M.D.		3023 Eastern Ave. Baltimore, Md			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		1-24-69		OAK LAWN CEM.	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR		24F. ADDRESS	
BALTO., Md.		Hollmann Funeral Home		3218 Hudson St.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 23 1969		Robert E. Finkbeiner		Hollmann Funeral Home	

X

Page 2 of 2

3-1-1974

USA

John Cook

and 11:55 AM - 12:00 PM

Page 2 of 2

M W

SHARON

Peter Gordon

STATE

Page 2 of 2

11:55 AM - 12:00 PM



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

69 0796

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mamie C. Mares

2. DATE AND HOUR OF DEATH

1/22/69 9:05 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)HOUSE OF PINES NURSING HOME  
70 BELAIR RD.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

818 N. MONTFORD AVE.

5. SEX

F

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

8-28-1879

9. AGE (In years  
lost birthday)

89

If Under 1 Yr.

Months

Days

If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

HOME

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

EDWARD GARRISON

14. MOTHER'S MAIDEN NAME

CHARLOTTE CURRY

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Leroy Woelfer - 7006A Mornington Rd.

18.

4539 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION lost.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Acute Pneumonia

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

4 days.

(B) DUE TO, OR AS A CONSEQUENCE OF:

Atherosclerosis

A A

(C) DUE TO, OR AS A CONSEQUENCE OF:

Multiple Coronal Thrombosis

&gt; 1 yr.

Chronic Congestive Heart Failure

1 year.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/10/19 68 to 1/22/19 69,  
that (I) (we) last saw the deceased alive on 1/18/19 69 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Albert B. Bradley

DEGREE

Attending  
Phys. ☒Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

1/22/69

23C. PHYSICIAN'S  
NAME (Type)

23D. ADDRESS

DEGREE

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

BURIAL

1-25-69

BALTIMORE REM.

BALTO., MD.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JAN 23 1969

Robert E. Fickens

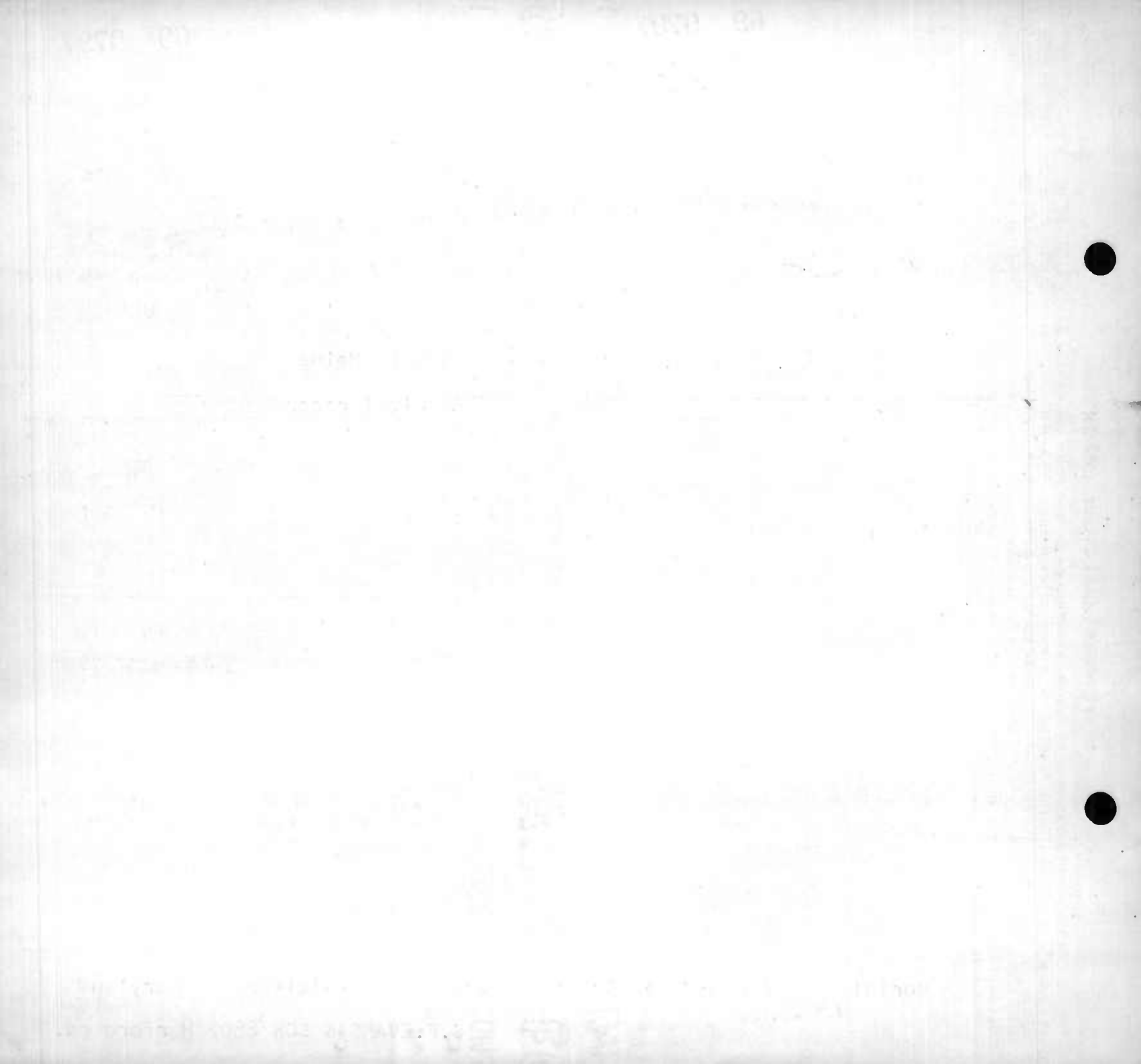
2334 Jefferson St.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. <span style="font-size: 2em;">69 0797</span>
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Bushman JEANNETTE A.</i>		2. DATE AND HOUR OF DEATH <i>1-20-69 11:55 p.m.</i>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland.</i> B. COUNTY <i>Baltimore</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>34 Bon Secours Hosp.</i>		C. CITY OR TOWN <i>Baltimore 21228</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <i>F.</i>		6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>4-4-87</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>At home</i>		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <i>81</i>
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Rosenberger, Lawrence</i>		14. MOTHER'S MAIDEN NAME <i>Sophie Heine</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Hospital records</i>
18. <i>436.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <i>C.V.A. and dehydration</i>		CAUSE OF DEATH <i>severe dehydration</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Three after-noon</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>severe dehydration</i>		
(B) DUE TO, OR AS A CONSEQUENCE OF:				
(C) DUE TO, OR AS A CONSEQUENCE OF:				
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <i>1-8-1969</i> to <i>1-20-1969</i> , that (I) (we) last saw the deceased alive on <i>1-20-1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>H. Makipour</i>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <i>H. MAKIPOUR</i>
24A. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/24/69</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cem</i>
24D. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>		25A. DATE REC'D. JAN 23 1969		
25B. NAME OF REGISTRAR <i>John E. Taylor</i>		25C. FUNERAL DIRECTOR <i>G. F. EVANS &amp; SON 8802 Harford rd.</i>		



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>PAULINE COLE</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 1 22 69 3:00 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION ADDRESS OR LOCATION <b>2304 Eutaw Place</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 22, 1969 3:00 a.m.</b>	
6. SEX <b>Female</b>		7. RACE <b>Colored</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>13-03</b>	
9. DATE OF BIRTH <b>Oct</b>		10. AGE (In years last birthday) <b>51</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Los Gury - N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Levie McLeod</b>		14. MOTHER'S MAIDEN NAME <b>Addie M. Lanier</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		16. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		18. SOCIAL SECURITY NO.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Carcinoma of the head of the pancreas with metastasis to liver and lung</b>	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>YES</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Edward F. Wilson</b> M.D. EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b> DATE SIGNED <b>1/22/69</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>1/26/1969</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Now Zion</b>		24D. LOCATION (City, town, or county) (State) <b>SANFORD N.C.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>	
25C. FUNERAL DIRECTOR <b>Marshall P. Hyatt</b>		25D. ADDRESS <b>638 N. Johns St - For</b>	

UNITED STATES DEPARTMENT OF JUSTICE

TO THE ATTORNEY GENERAL  
FROM THE DIRECTOR

RE: [Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

MAILED  
JUL 15 1954  
FBI

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

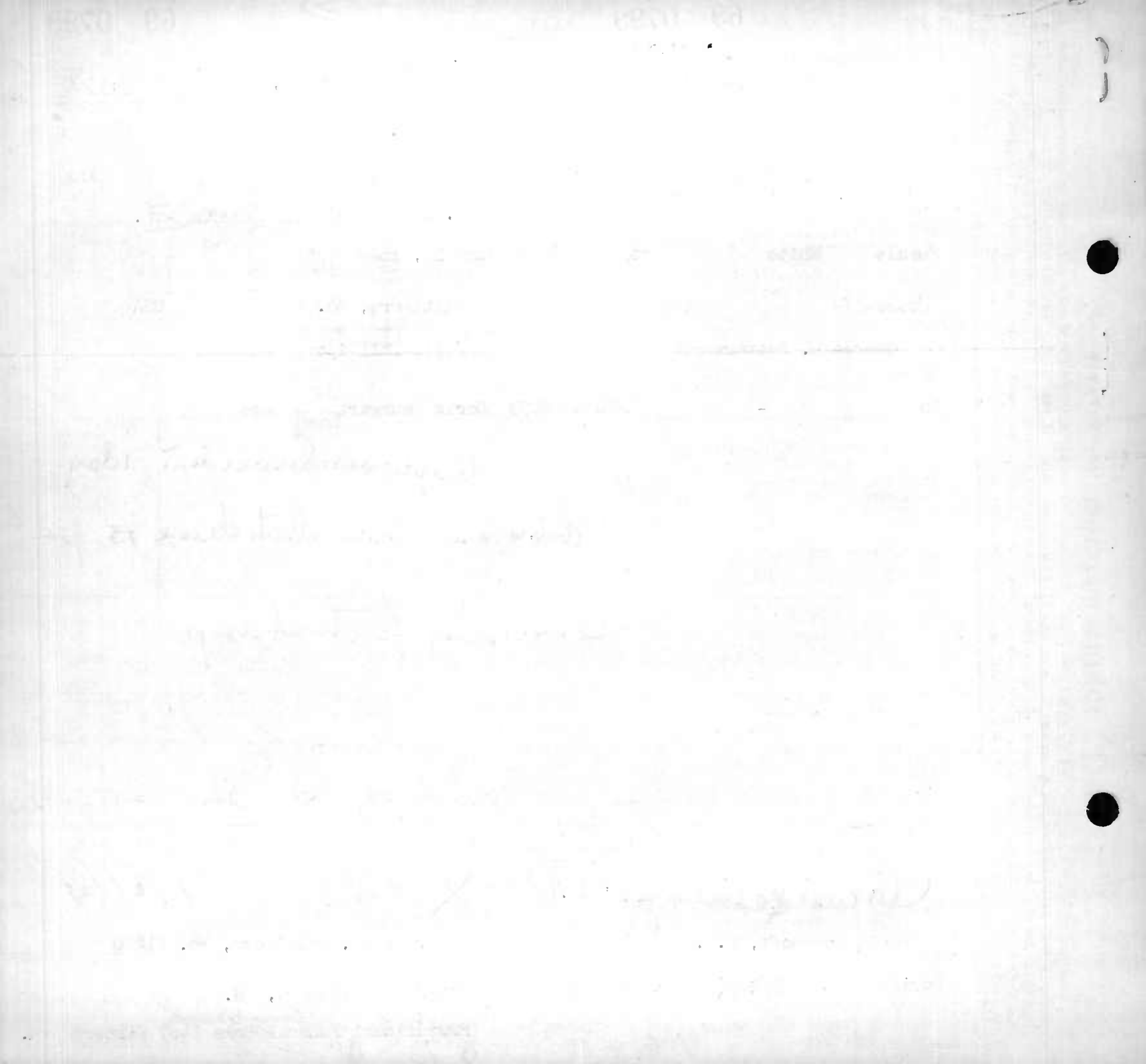
69 0799

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

69 0799

1. NAME OF DECEASED (Type or Print) <b>MARY LOUISE BRANT</b>		2. DATE AND HOUR OF DEATH <b>January 21, 1969</b> <b>3:55 AM</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 Gould Convalesarium 6116 Belair Road</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Middle River 21220</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>Rt. 15 Box 221 Susquehanna Ave.</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 13, 1884</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	9. AGE (In years last birthday) <b>84</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George W. Butterworth</b>		14. MOTHER'S MAIDEN NAME <b>Julia Phillips</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220 46 8073</b>	
17. INFORMANT <b>Doris Baumgart</b>		ADDRESS <b>Same</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>437.91</b> <b>Cerebro-vascular accident</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebro-vascular accident</b> (B) <b>Cerebro-vascular disease 15 years</b> (C) <b>Convolensing fractured hip</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Convolensing fractured hip</b>			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>home add Rt 15 Box 221</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>1/15/68 7:30 PM</b>	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>fell while trying to get on chair</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>March 27 1956</b> to <b>Jan 21 1969</b> , that (I) (we) last saw the deceased alive on <b>Jan 21 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Louis Semenoff</b>		23B. DATE SIGNED <b>1/21/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Louis Semenoff, M.D.</b>		23D. ADDRESS <b>2108 Orems Rd. Baltimore, Md. 21220</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1/24/69</b>	24C. NAME of CEMETERY or CREMATORY <b>Gardens of Faith Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1969</b>	25B. NAME OF REGISTRAR <b>Robert E. Jankovics</b>	25C. FUNERAL DIRECTOR <b>Bruzdinski</b>	ADDRESS <b>Bruzdinski Funeral Home 1407 Eastern Ave.</b>





# FUNERAL DIRECTOR: IMPORTANT

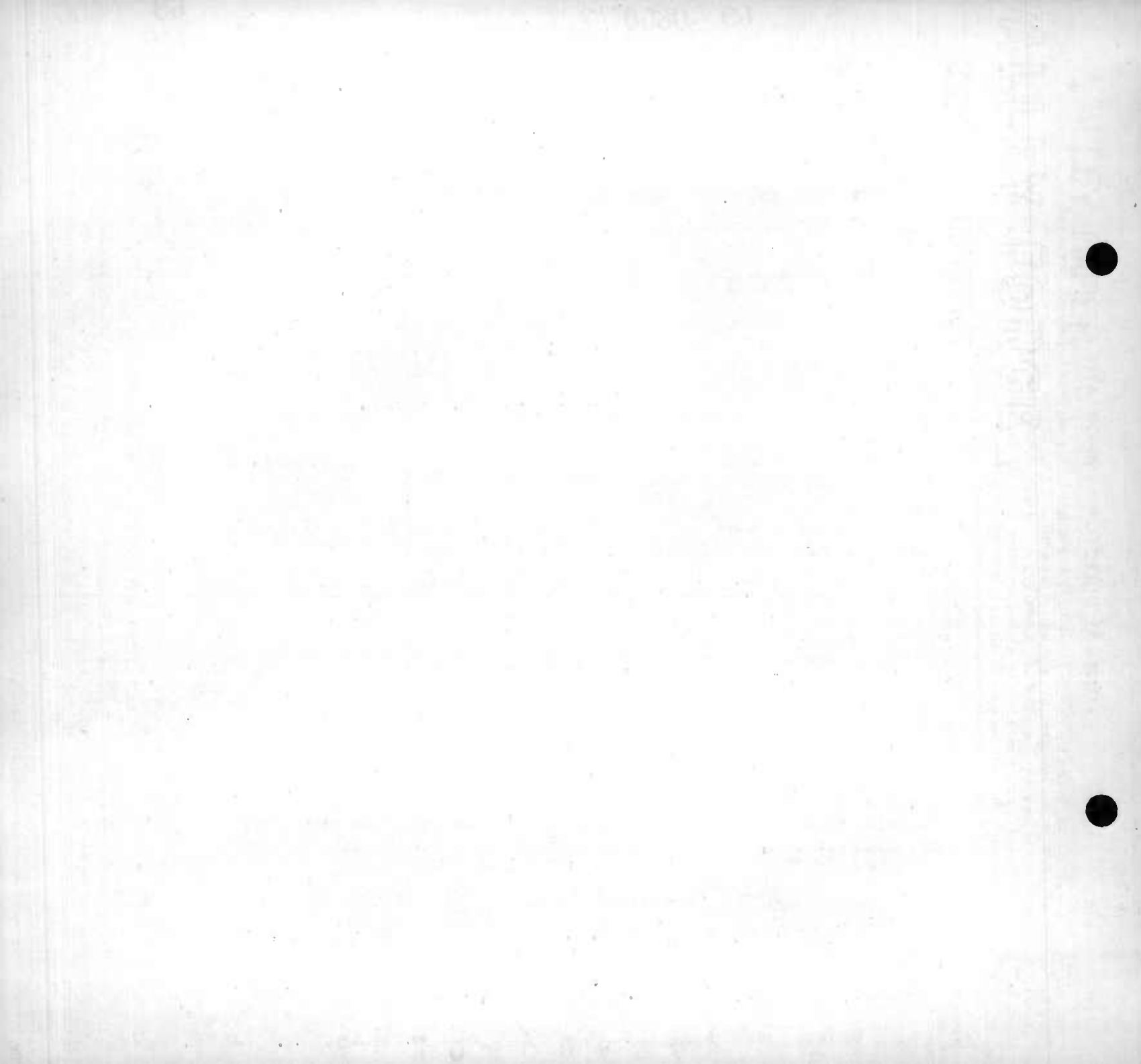
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0800

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

69 0800 REG. NO.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Ella M. Steigerwald</i>		2. DATE AND HOUR OF DEATH <i>Jan. 20, '69</i> <i>4 A</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>16-10</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>00</i>			C. CITY OR TOWN <i>Baltimore</i>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>28 N. Clinton Street</i>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <i>28 N. Clinton St.</i>					
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/12/83</i>	9. AGE (In years last birthday) <i>85</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>William Mason</i>			14. MOTHER'S MAIDEN NAME <i>Virginia Knight</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-09-5513A</i>	17. INFORMANT <i>Mr. John F. Steigerwald</i>		
18. <i>4/10/91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Art Sci C.V. disease</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Smoking</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Sept 19 68</i> to <i>1/20 19 69</i> , that (I) (we) last saw the deceased alive on <i>1/18 19 69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Julius H. Goodman</i>			23B. DATE SIGNED <i>1/21/69</i>		
23C. PHYSICIAN'S NAME (Type) <i>Julius H. Goodman M.D.</i>			23D. ADDRESS <i>9 S Highland Ave</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/23/69</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt. Olivet Cemetery</i>	
24D. LOCATION <i>Baltimore, Maryland</i>		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 23 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>John A. Moran, Inc.</i>	
				ADDRESS <i>3000 E. Baltimore St</i>	





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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## 69 0802 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

69 0802

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Burnice P. Litchfield		January 21, 1969 4:25 AM.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) D.O.A. Union Memorial Hospital				A. STATE Md.	
				B. COUNTY	
C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 4126 Weldon Place West	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 7, 1915	9. AGE (In years last birthday) 53
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10B. KIND OF BUSINESS OR INDUSTRY Farnen & Dermer		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Burnice Parker	
14. MOTHER'S MAIDEN NAME Ida Litchfield				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II	
16. SOCIAL SECURITY NO. 216-05-7564				17. INFORMANT Jas. E. Litchfield-3629 Keystone Ave.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 weeks ?	
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-17 1968 to 1-21 1969, that (I) (we) last saw the deceased alive on 1-20 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Reuben Hoffman, M.D.				23B. DATE SIGNED 1-21-69	
23C. PHYSICIAN'S NAME (Type) Reuben Hoffman, M.D.				23D. ADDRESS 846 W. 36th, BALTIMORE, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/24/69		24C. NAME OF CEMETERY or CREMATORY Sater's Cemetery	
24D. LOCATION Balto. County,		24E. (State) Md.			
25A. DATE REC'D. BY HEALTH DEPT. JAN 23 1969		25B. NAME OF REGISTRAR Robert E. Fairman		25C. FUNERAL DIRECTOR Austin E. Donovan-3818 Roland Ave.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0803

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 69 0803

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Clara P. Kuzminski</i>		2. DATE AND HOUR OF DEATH <i>11/21/69</i> <i>6:30</i> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <i>Md</i> B. COUNTY <i>18-03</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>00815 Hollins St.</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>1st Baster</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Clothing Co.</i>		8. DATE OF BIRTH <i>7/16/1906</i> 9. AGE (In years lost birthday) <i>62</i>	
11. BIRTHPLACE (State or foreign country) <i>Lithuania</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Pete Paulauskas</i>		14. MOTHER'S MAIDEN NAME <i>Frances Stankiewicz</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>✓</i>	
16. SOCIAL SECURITY NO. <i>218-053622</i>		17. INFORMANT <i>Mr Stanley Kuzminski</i>		ADDRESS <i>above</i>	
18. <i>2778 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute massive myocardial infarction</i> (B) <i>C.S.C.V.D.</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Severe obesity</i> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1954</i> to <i>Jan 31</i> 1969, that (I) (we) last saw the deceased alive on <i>Jan 21</i> 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Stanley Ankudas</i>		23B. DATE SIGNED <i>1/22/69</i>		23C. PHYSICIAN'S NAME (Type) <i>Stanley Ankudas, M.D.</i>	
23D. ADDRESS <i>1101 Maiden Choice Lane #21229</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/25/69</i>		24C. NAME OF CEMETERY or CREMATORY <i>David Ridge Cem.</i>	
24D. LOCATION <i>Pikesville Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 23 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Fagundes</i>		25C. FUNERAL DIRECTOR <i>John J. Cowan &amp; Son Inc.</i>	
25D. ADDRESS <i>23 Md.</i>					

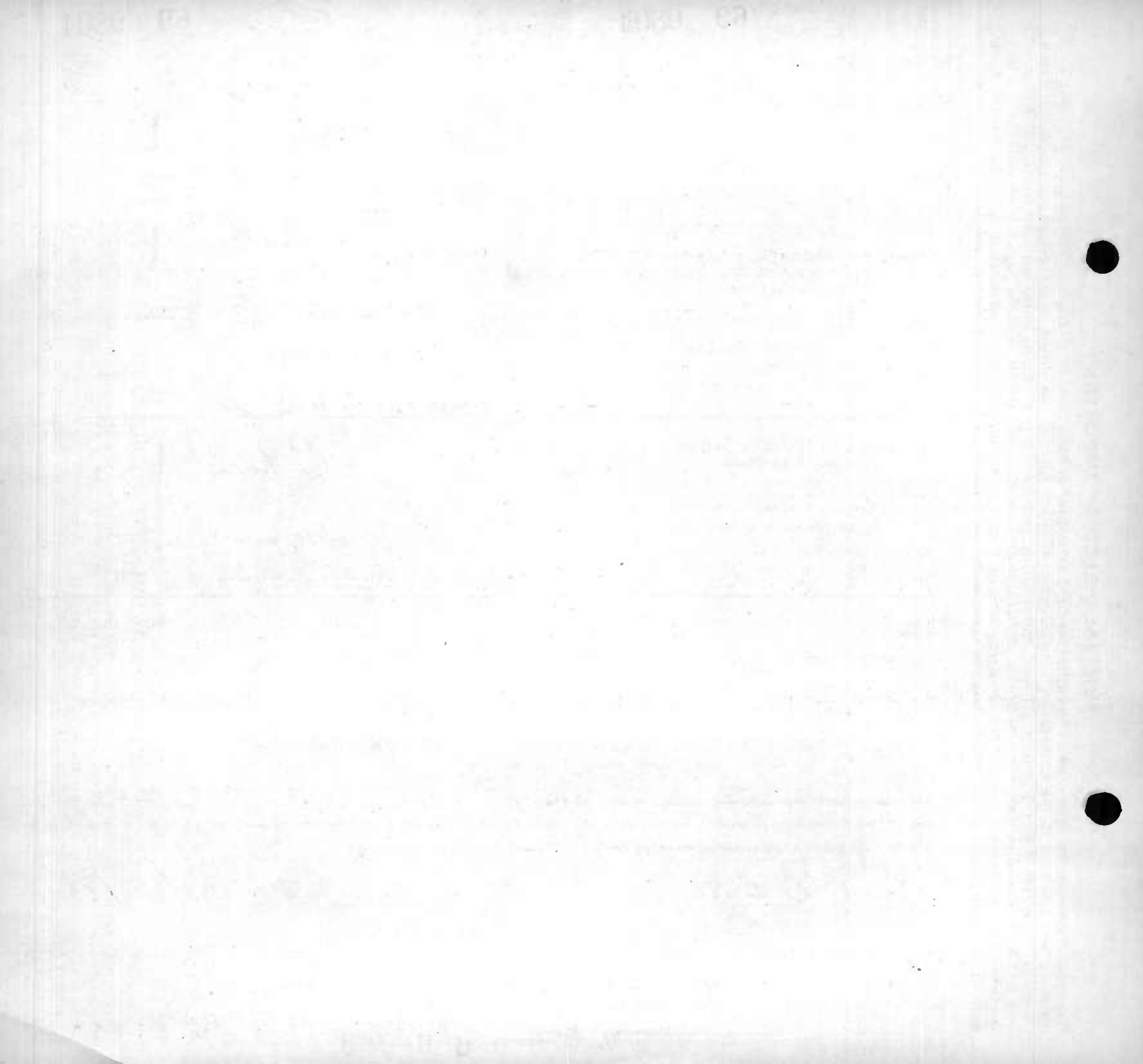




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>69 0804</b>
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <i>Elizabeth H. Kehs</i>		<b>2. DATE AND HOUR OF DEATH</b> <i>1/22/69 8<sup>00</sup>A</i> M.		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> <i>00</i> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>5837 Belair Road</i> <i>Baltimore, Md.</i>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> 21218 B. COUNTY <b>C. CITY OR TOWN</b> <i>Baltimore</i> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <i>521 Chestnut Hill Avenue</i>		
<b>5. SEX</b> <i>Female</i>	<b>6. RACE</b> <i>White</i>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <i>March 31, 1889</i>	<b>9. AGE</b> (In years lost birthday) <i>79</i>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <i>---</i>		
<b>11. BIRTHPLACE</b> (State or foreign country) <i>Balto. Maryland</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>USA</i>		
<b>13. FATHER'S NAME</b> <i>Louis Contee</i>		<b>14. MOTHER'S MAIDEN NAME</b> <i>Martha E. Travers</i>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		<b>16. SOCIAL SECURITY NO.</b> <i>220-44-9160</i>		
<b>17. INFORMANT</b> <i>Robert F. Kehs (Son)</i>		<b>ADDRESS</b> <i>Same</i>		
<b>CAUSE OF DEATH</b>				
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> <i>437.91-250.9 Cachexia</i>				
<b>19. ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Smile Depression</i>				
<b>20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b> <i>Diabetes mellitus</i>				
<b>19A. DATE OF OPERATION</b> <i>0</i>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <i>1/5/69</i> <b>to</b> <i>1/22/69</i> , <b>that (I) (we) last saw the deceased alive on</b> <i>1/18/69</i> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <i>Albert B. Bradley</i>				<b>23B. DATE SIGNED</b> <i>1/22/69</i>
<b>23C. PHYSICIAN'S NAME</b> (Type) <i>Albert B. Bradley</i>		<b>23D. ADDRESS</b> <i>4900 Belair Road Balto. Md.</i>		
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <i>Burial</i>		<b>24B. DATE</b> <i>1/25/1969</i>		
<b>24C. NAME OF CEMETERY or CREMATORY</b> <i>Lorraine Park Cemetery</i>		<b>24D. LOCATION</b> (City, town, or county) (State) <i>Baltimore, Md.</i>		
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <i>JAN 23 1969</i>		<b>25B. NAME OF REGISTRAR</b> <i>Robert E. Seitz</i>		<b>25C. FUNERAL DIRECTOR</b> <i>Eugenia K. Seitz 5209 York Rd. Seitz Funeral Home Balto. Md. 21212</i>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 0805	
BIRTH NO. 1		1. NAME OF DECEASED (Type or Print) <u>Samuel Barr</u>		2. DATE AND HOUR OF DEATH <u>21 Jan 1969</u> <u>5:45 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>BALTIMORE</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>OWINGS MILLS</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5. SEX <u>MALE</u> 6. RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL</u> <u>42</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		8. DATE OF BIRTH <u>3-19-1911</u> 9. AGE (In years lost birthday) <u>57</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>RETAIL</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	
13. FATHER'S NAME <u>PHILIP BARGROSSER</u>		14. MOTHER'S MAIDEN NAME <u>REBECCA POLLACK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. BEULAH BARR, OWINGS MILLS, MARYLAND</u>	
18. <u>410.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary occlusion</u> (B) <u>Coronary insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 h.</u> <u>1 month</u> <u>7 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>Jan 14</u> 19 <u>69</u> to <u>Jan 21</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Jan 14</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <u>Joseph B Gross</u>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>Joseph B Gross</u>	
23D. ADDRESS <u>6911 Park Heights Rd Balt 15 Md</u>		23E. NAME OF REGISTRAR <u>John C. Sullivan</u>		23F. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-22-69</u>		24C. NAME OF CEMETERY or CREMATORY <u>AGUDAS B'NAI JACOB LODGE</u>	
24D. LOCATION (City, town, or county) <u>ROSEDALE, MARYLAND</u>		24E. DATE RECEIVED BY HEALTH DEPT. <u>JAN 23 1969</u>		24F. ADDRESS <u>6911 Park Heights Rd Balt 15 Md</u>	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death, shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-654		69 0806		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 0806	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
MAX ARNOLD				JANUARY 20, 1969 12:48 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL 42				A. STATE MARYLAND B. COUNTY Balto co. 53-00			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
5. SEX MALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 9-3-1884 9. AGE (In years last birthday) 84			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LEATHER GOODS				10B. KIND OF BUSINESS OR INDUSTRY MANUFACTURER			
11. BIRTHPLACE (State or foreign country) AUSTRIA				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME MAURICE ARNOLD				14. MOTHER'S MAIDEN NAME ROSLYN SOPHEN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 177-09-8703			
17. INFORMANT MISS ROSLYN ARNOLD, 6800 LIBERTY RD., APT. 514				ADDRESS			
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Atherosclerotic heart disease acute myocardial infarction (B) DUE TO, OR AS A CONSEQUENCE OF: (C).....			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21F. HOW DID INJURY OCCUR?			
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1/30/65 to 1/11/69, that (I) (we) last saw the deceased alive on 1-11-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE DR. RAFAEL PEREZ-MERA				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) DR. RAFAEL PEREZ-MERA				23D. ADDRESS 7306 LIBERTY ROAD			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 1-22-69			
24C. NAME OF CEMETERY or CREMATORY KNOLLWOOD PARK CEMETERY				24D. LOCATION (City, town, or county) (State) BROOKLYN, NEW YORK			
25A. DATE REC'D BY HEALTH DEPT. JAN 23 1969				25B. NAME OF REGISTRAR R. E. F. F. F.			
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				ADDRESS			

Page 10 of 10

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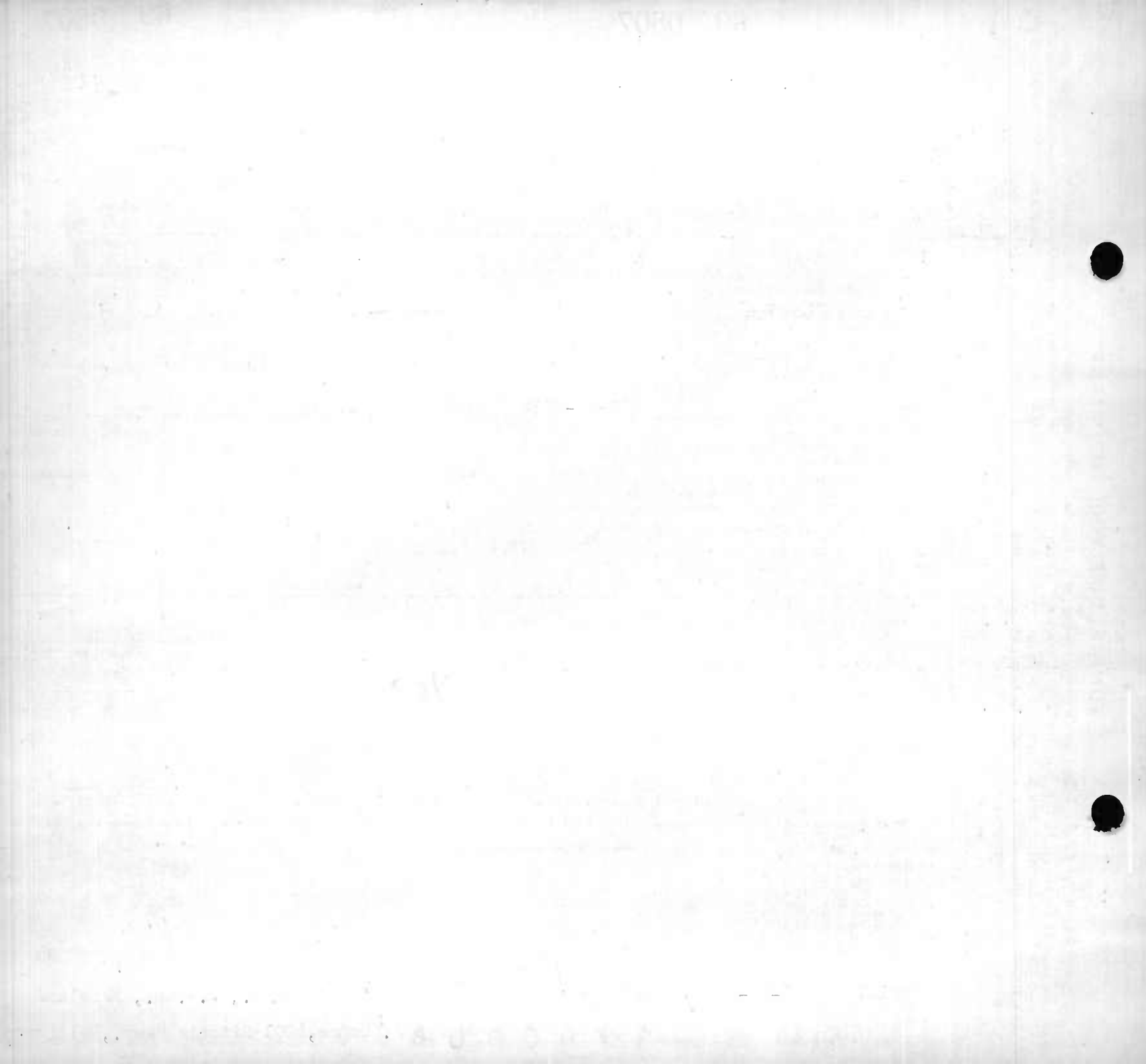
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# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		69 0807	
1. NAME OF DECEASED (Type or Print) <b>Helen A. Bell</b>				2. DATE AND HOUR OF DEATH <b>1-17-69</b> <b>12<sup>45</sup> P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>43 South Baltimore General Hospital</b>				A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> <b>53-00</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>402 Second Ave.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-25-06</b>	9. AGE (In years last birthday) <b>62</b>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Kasper Rybikowsky</b>				14. MOTHER'S MAIDEN NAME <b>Eufrozina Botka</b>			
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-10-5038</b>		17. INFORMANT <b>Hospital Records</b>		ADDRESS	
18. <b>1977-8 I</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Carcinoma of Liver</b> <b>&amp; metastases, prob to lung</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1-13</b> <b>1969</b> to <b>1-17</b> <b>1969</b> , that <del>the</del> <b>(we)</b> last saw the deceased alive on <b>1-17</b> <b>1969</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> <b>(we)</b> (did) <del>(did not)</del> view the body after death.							
23A. SIGNATURE <b>Stanley R. Weimer, M.D.</b>				23B. DATE SIGNED <b>1-17-69</b>		23C. PHYSICIAN'S NAME (Type) <b>Stanley R. Weimer M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-21-1969</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Cross Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Ritchie Hwy., A.A.Co., Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1969</b>		25B. NAME OF REGISTRAR <b>George J. Gorce</b>		25C. FUNERAL DIRECTOR <b>George J. Gorce, 4001 Ritchie Hwy., Baltimore</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68-17914		69 0808		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 0808	
1. NAME OF DECEASED (Type or Print) <b>PRUETT, TRAVIS A.</b>				2. DATE AND HOUR OF DEATH <b>1-17-69</b> <b>645 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SOUTH BALTIMORE GENERAL HOSP.</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>25-34</b>			
				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>115 W. JEFFREY ST</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-22-68</b>	9. AGE (in years last birthday) <b>0</b>	10. If Under 1 Yr. Months Days Hours Min. <b>3 26</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>	
13. FATHER'S NAME <b>SHERMAN PRUETT</b>				14. MOTHER'S MAIDEN NAME <b>JUDITH HALL</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Mr. Sherman Pruett, 115 W. Jeffrey St.</b>	
18. <b>009.21</b>				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>BRONCHOPNEUMONIA</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ENTERITIS</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) <b>ENTERITIS</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>3-1-69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>TRACHEOTOMY - RESPIRATORY DIFFICULTY FROM PNEUMONIA</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1-3-69</b> to <b>1-17-69</b> that (I) (we) last saw the deceased alive on <b>1-17-69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Jose H. Glesias Jr.</b>				23B. DATE SIGNED <b>1-17-69</b>		23C. PHYSICIAN'S NAME (Typo) <b>Jose V. F. Glesias M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-20-1969</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial Park</b>		24D. LOCATION (City, town, or county) (Total) <b>Ritchie Hwy., A.A.Co., Maryland</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>JAN 23 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>		25C. FUNERAL DIRECTOR <b>George J. Gonde, 4001 Ritchie Hwy., Baltimore</b>			

Section 1, 1892

1892

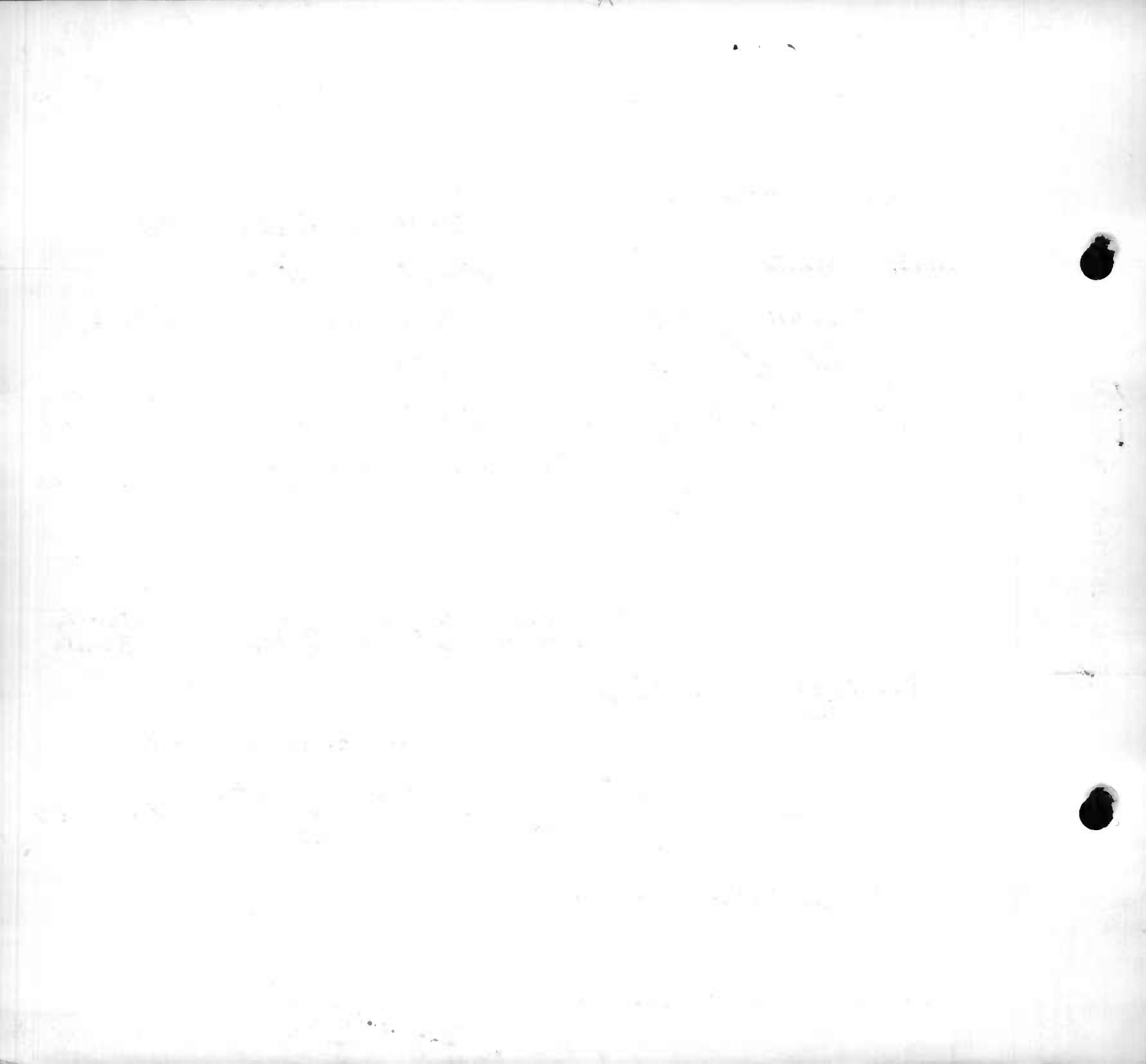
1892

Section 1, 1892  
1892

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="font-size: 1.5em;">69 0809</span>	
BIRTH NO. <span style="font-size: 1.5em;">69 0809</span>		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Albert McDermott</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">11/18/68 69 13<sup>45</sup> P.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">42 Sinai Hospital</span>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence below admission) A. STATE <span style="font-size: 1.2em;">Md</span> B. COUNTY <span style="font-size: 1.2em;">27-10</span> C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE -15</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">6209 REISTERSTOWN Rd</span>		
5. SEX <span style="font-size: 1.2em;">MALE</span>	6. RACE <span style="font-size: 1.2em;">WHITE</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">DEC. 9, 1898</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">70 yrs.</span>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">TAVERN</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">SEMT-EMPLOYED</span>	11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">NEW YORK N.Y.</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>
13. FATHER'S NAME <span style="font-size: 1.2em;">John McDermott</span>			14. MOTHER'S MARDEN NAME <span style="font-size: 1.2em;">Mary Cooke</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">None</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">282-36-1651</span>	17. INFORMANT <span style="font-size: 1.2em;">Mrs. Edna A. McDermott</span>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Middle Cerebral Artery Occlusion</span>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">3 weeks</span>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.2em;">Pneumonia @ Lobar</span>			DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Intertrophaneuric A @ hip</span>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <span style="font-size: 1.2em;">Pneumonia @ Lobar</span>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">3 weeks</span>		
19A. DATE OF OPERATION <span style="font-size: 1.2em;">Dec 22, 68</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.2em;">Fx @ hip</span>		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <span style="font-size: 1.2em;">home</span>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <span style="font-size: 1.2em;">6209 Reisterstown Rd 27-10</span>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <span style="font-size: 1.2em;">12/26/68 9:00 P.</span>		21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <span style="font-size: 1.2em;">Fall down steps</span>	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">12/26</span> 19 <span style="font-size: 1.2em;">68</span> to <span style="font-size: 1.2em;">1/18</span> 19 <span style="font-size: 1.2em;">69</span> that (I) (we) lost saw the deceased alive on <span style="font-size: 1.2em;">1/18</span> 19 <span style="font-size: 1.2em;">69</span> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Stanford H. McHenry MD</span>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
<span style="font-size: 1.2em;">Burial Jan 21/69 Western Cemetery</span>		<span style="font-size: 1.2em;">JAN 23 1969</span>		<span style="font-size: 1.2em;">Baltimore, Md.</span>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<span style="font-size: 1.2em;">JAN 23 1969</span>		<span style="font-size: 1.2em;">Robert E. Jackson</span>		<span style="font-size: 1.2em;">Frank H. Newell Pikeville</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 0810
BIRTH NO.		69 0810		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Joseph E. Johnson			Jan. 11 <sup>th</sup> 1969 15 <sup>50</sup> A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 33 John Hopkin Hosp.			A. STATE Maryland		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY 7-04		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 825 N. Wolfe St.		
5. SEX Male	6. RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 70	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Warrenton, Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Johnson		14. MOTHER'S MAIDEN NAME Elizabeth Johnson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-30-6333T		17. INFORMANT Corn Johnson	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ARTERIO-SCLEROTIC HEART DISEASE		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to JANUARY 11 1969, that (I) (we) last saw the deceased alive on January 3 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Bernard Harris Sr.				23B. DATE SIGNED 1/21/69	
23C. PHYSICIAN'S NAME (Type) Bernard Harris Sr.				23D. ADDRESS 1202 N. Caroline St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan. 15, 1969		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem.	
24D. LOCATION (City, town, or county) Brooklyn		24E. STATE Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 23 1969	
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR E. B. Wilson		25D. ADDRESS 1000 Brantly Ave.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 0811
BIRTH NO.		69 0811		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>CLOAK N. BOWDEN</b>		2. DATE AND HOUR OF DEATH <b>1/22/69</b> <b>12:00 Noon</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>9-05</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE UNION MEMORIAL HOSP.</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
ADDRESS OR LOCATION <b>33rd &amp; Calvert Sts.</b>		E. STREET AND NUMBER <b>3152 Eilers Rd. St.</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. <del>MARRIED</del> <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/22/1875</b>	9. AGE (In years last birthday) <b>94</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <del>Albert Bowden</del> <b>Albert Bowden</b>		14. MOTHER'S MAIDEN NAME <del>Mary Dennis</del> <b>Mary Dennis</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>OLIVER GANDY</b>	
18. <b>486X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia.</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pneumonia.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>OLD AGE.</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b></b>		(C) DUE TO, OR AS A CONSEQUENCE OF: <b></b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b></b>					
19A. DATE OF OPERATION <b>NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NONE</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NONE</b>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NONE</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>NONE</b>			
21D. TIME OF INJURY (APPROX.) <b></b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b></b>	
22. I certify that (I) (this hospital) attended the deceased from <b>1-17-69</b> to <b>1-22-69</b> and that (I) (we) last saw the deceased alive on <b>1-22-69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) <b>view</b> the body after death.					
23A. SIGNATURE <b>Antonio P. Carmody</b>		23B. DATE SIGNED <b>1-22-69</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. FRANCIS CARMODY</b>	
23D. ADDRESS <b>Edmondson Ave., 21229</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>1/25/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1969</b>		25B. NAME OF REGISTRAR <b>Edmondson Ave., 21229</b>		25C. FUNERAL DIRECTOR <b>Witzke, 4101 Edmondson Ave., 21229</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>George Eppler</b>				2. DATE AND HOUR OF DEATH <b>1/21/69 4:15 P.M.</b>				69 0812			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				A. STATE <b>Md.</b> B. COUNTY <b>21-02</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>University of Md.</b>				C. CITY OR TOWN <b>Baltimore</b>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <b>1120 W. Cross St, 21230</b>							
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/20/91</b>	9. AGE (in years last birthday) <b>77</b>	If Under 1 Yr. Months: Days: Hours: Min.		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Md.</b>			
13. FATHER'S NAME <b>J. George Eppler</b>				14. MOTHER'S MAIDEN NAME <b>Katherine Kraemer</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>WWI 6/24/1918-</b>				16. SOCIAL SECURITY NO. <b>218-42-8042</b>				17. INFORMANT <b>H. J. Record</b>			
18. <b>201X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <b>Gram negative sepsis</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Infected wound/cellulitis</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Hodgkin's disease - stage IV</b>											
19A. DATE OF OPERATION <b>1/20/69</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Exploration - biopsy</b>				20A. AUTOPSY? (Yes or No) <b>NO</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1/12/69</b> to <b>1/21/69</b> and that (I) (we) last saw the deceased alive on <b>1/21/69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>Marvin Sachs, M.D.</b>				23B. DATE SIGNED <b>1-21-69</b>							
23C. PHYSICIAN'S NAME (Type) <b>MARVIN C. SACHS, M.D.</b>				23D. ADDRESS <b>Univ. H. J. Record</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>1/24/69</b>				24C. NAME of CEMETERY or CREMATORY <b>Baltimore National</b>			
24D. LOCATION <b>Baltimore, Md.</b>											
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1969</b>				25B. NAME OF REGISTRAR <b>Robert E. Galt</b>				25C. FUNERAL DIRECTOR <b>Witzke, 4101 Edmondson Ave. 21229</b>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 0813
BIRTH NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Verbie Schupp		11/23/69 5:45 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
		A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
48 Maryland General Hosp		Baltimore 21234		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
F		W		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
HOMEMAKER		OWN HOME		2-16-1895	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (in years lost birthday)	
THOMAS GRIFFIN		LULU MOORE		73	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		212-18-5326A		MISS MARGARET SCHUPP.	
18. 158.0 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		wks.	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(C) Retroperitoneal carcinoma		months	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II		ASCVD		yr.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
11/18/69		Abdominal mass		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 11/3/69 to 11/23/69, that (I) (we) last saw the deceased alive on 11/23/69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Louis E. Grenzer		11/23/69			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. Louis E. Grenzer		Maryland General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1/25/69		Baltimore	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 23 1969		Robert E. Jenkins		H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0814 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 65 0814

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ROBERT EARL GRANT</b>		2. DATE AND HOUR OF DEATH <b>JANUARY 22, 1969   8:25 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>KISWICK HOME FOR INCURABLES</b> <b>700 W 40TH ST</b>			A. STATE <b>MARYLAND</b>		B. COUNTY <b>13-07</b>
			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>700 W. 40th St.</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC 20, 1914</b>	9. AGE (In years last birthday) <b>54</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Acct.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>J.M. LAWRENCE CO.</b>		11. BIRTHPLACE (State or foreign country) <b>CHICAGO, ILLINOIS</b>	
13. FATHER'S NAME <b>ROBERT GRANT</b>			14. MOTHER'S MAIDEN NAME <b>MARY M. PRINITY</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-18-8387</b>		17. INFORMANT <b>ELIZABETH GREGORY RN.</b>	
				ADDRESS <b>700 W 40th St.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>E989X</b> <b>Aspiration Pneumonia</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Spastic Quadraplegia</b>			(B) DUE TO, OR AS A CONSEQUENCE OF: <b>38 yrs</b>		
			(C) <b>Head Injury - post-operative</b> <b>38 yrs</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1 June 1961</b> to <b>22 JAN 1969</b> , that (I) (we) last saw the deceased alive on <b>22 JAN 1969</b> and that (I) (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Aubrey D. Richardson</b>				23B. DATE SIGNED <b>22 JAN 1969</b>	
23C. PHYSICIAN'S NAME (Type) <b>Aubrey D. Richardson, M.D.</b>		23D. ADDRESS <b>700 W. 40th Street</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/25/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn</b>	
24D. LOCATION <b>Woodlawn, Balto. Co., Md.</b>		24E. LOCATION (City, town, or county) (State) <b>Balto. Co., Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
69 0815				69 0815	
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		EMMA F. GISHIN		JANUARY 21st, 1969 3:07 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			MARYLAND BALTO. CO. GLEN ARM 53-00		
UNION MEMORIAL HOSPITAL			C. CITY OR TOWN D. INSIDE CITY LIMITS? ROUTE 1, Box 249-5 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER 21057					
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
FEMALE	WHITE		10-22-92	76	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE		OWN HOME		MARYLAND	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
JOHN H. FOSS.			(AMERICAN) U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
NO			212-50-5013		
17. INFORMANT			ADDRESS		
MRS. JANE G. THOMPSON (CHART)			3810 BEECH AVE.		
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  Myocardial Infarction  Arteriosclerotic Cardiovascular Disease  (B) DUE TO, OR AS A CONSEQUENCE OF:  Disease  (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
NO					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-16-1969 to 1-21-1969, that (I) (we) last saw the deceased alive on 1-21-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Cesar A. Bravo M.D.				1/21/69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
CESAR A. BRAVO M.D.				UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1/25/69		Druid Ridge	
				Pikesville, Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 23 1969		John E. Jenkins		H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.	

UNION MEMORIAL HOSPITAL

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HOUSEWIFE

WARRAND

JOHN H. FORD

RATHBONE L. KILPATRICK

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M.D.

Signature

CEASE & DESIST UNION MEMORIAL HOSPITAL



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0816

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 69 0816

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>BOOTH, COZETTE A.</u>		2. DATE AND HOUR OF DEATH <u>1/20/69</u> <u>2:20 P.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>MERCY HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>27-48</u>		C. CITY OR TOWN <u>BALTO.</u>	
5. SEX <u>F</u>		6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>8/19/88</u>		9. AGE (In years lost birthday) <u>80</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>10WA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JOSEPH K. ALLINE</u>		14. MOTHER'S MAIDEN NAME <u>MILDRED BLISS</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>004-14-6495A</u>		17. INFORMANT <u>JAMES F. BOOTH (SAME)</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>4/2/51</u> <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <u>Pulmonary Embolism</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>ASHD, Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u> <u>NO</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NO</u>		20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>12/28</u> 19 <u>68</u> to <u>1/20</u> 19 <u>69</u> that (1) (we) last saw the deceased alive on <u>1/20</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Manuela Ribeiro</u>				23B. DATE SIGNED <u>1/21/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>MANUELA M. RIBEIRO, M.D.</u>		23D. ADDRESS <u>Mercy Hospital, Baltimore, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/24/69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Parkwood</u>	
24D. LOCATION (City, town, or county) (State) <u>Parkville, Balto. Co., Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 23 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co.</u>	
25D. ADDRESS <u>4905 York Rd.</u>					

Handwritten text, possibly a signature or name, appearing in the center of the page.

Handwritten text at the bottom right, possibly a date or reference number.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>MILBURN M. ALTVATER</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 1 21 69 8:10 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Church Home &amp; Hospital</b> <b>D.O.A.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 21, 1969 8:10 p.m.</b>	
6. SEX <b>Male</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>6-04</b>	
7. RACE <b>White</b>		C. CITY OR TOWN <b>Balto.</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>Aug. 26, 1894</b>		E. STREET AND NUMBER <b>2006 E. Balto. St.</b>	
10. AGE (In years last birthday) <b>74</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>	
12. CITIZEN OF <b>WHAT COUNTRY?</b>		13. FATHER'S NAME <b>William Altvater</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Shipyard</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Sparrows Point</b>	
15. MOTHER'S MAIDEN NAME <b>Elizabeth</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Mrs. Minnie Altvater</b>	
19. CAUSE OF DEATH <b>430X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>(A) IMMEDIATE CAUSE Bilateral pulmonary emboli</b> <b>(B) and Hypertensive arteriosclerotic cardiovascular disease</b> <b>(C)</b>	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No)			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Edward F. Wilson</b> M.D. EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1/22/69</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-25-1969</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore County, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fenderson</b>	
25C. FUNERAL DIRECTOR <b>Lilly &amp; Zeiler Inc.</b>		ADDRESS <b>1901-07 Eastern Ave.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

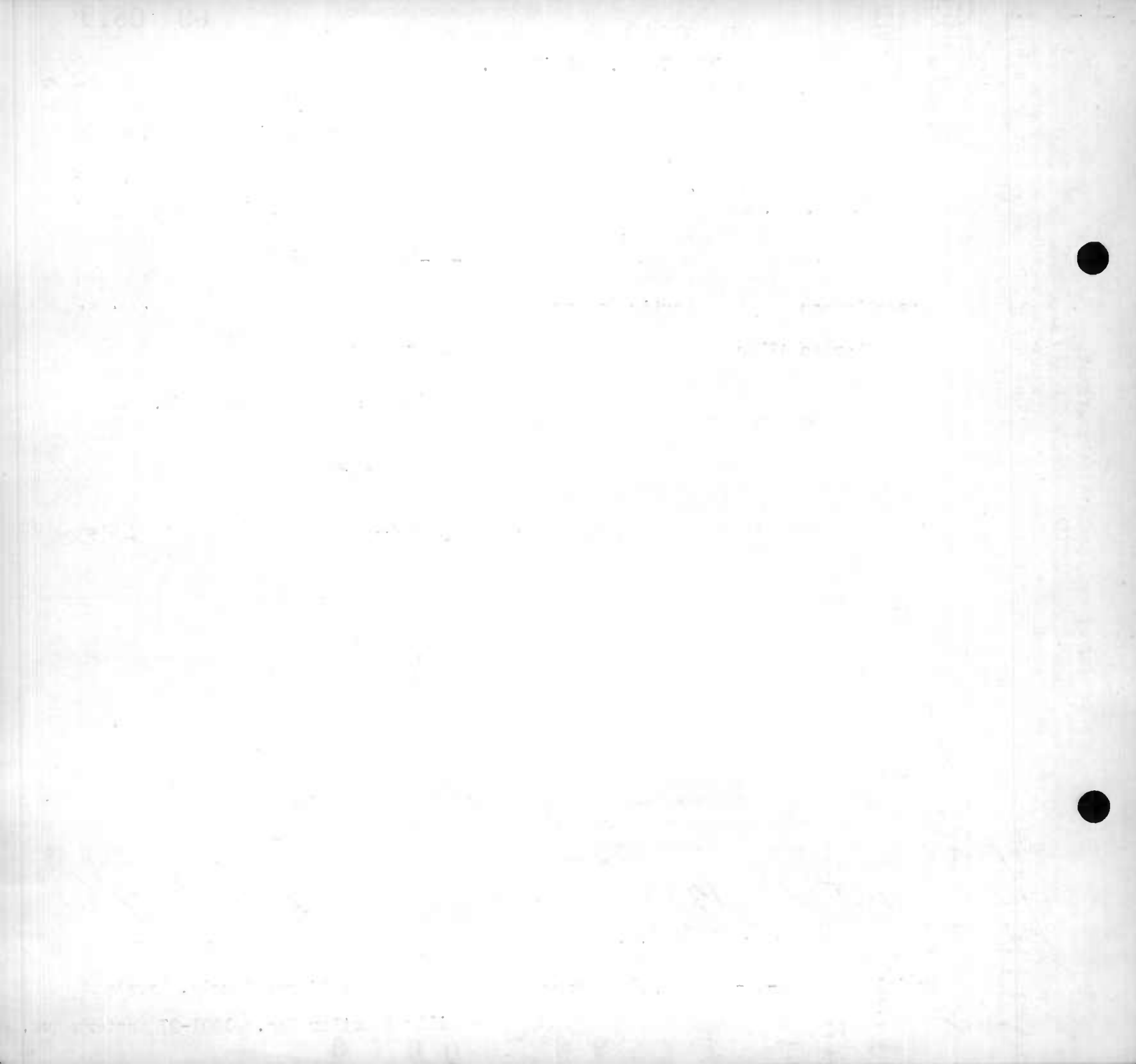
69 0818		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 69 0818	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>GORDON GEORGE HECK</b>		2. DATE AND HOUR OF DEATH <b>January 22, 1969</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>CERTIFICATE AMENDED</b> FULL NAME OF DECEASED (If not in hospital or institution, give street address or location) <b>00 2704 Fait Avenue</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1-03</b>			
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED, NEVER MARRIED <b>Married</b>	
8. DATE OF BIRTH <b>June 30, 1893</b>		9. AGE (In years last birthday) <b>75</b>		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Painter</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Gustav Heck</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Armandt</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-03-0897</b>		17. INFORMANT <b>Mrs. Catherine Heck</b>	
		ADDRESS <b>2704 Fait Avenue</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>185 X I</b> <b>Carcinomatous</b>		CAUSE OF DEATH (A) <b>Carcinomatous</b> DUE TO (B) <b>(Primary - Prostate)</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>Feb. 1968</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
21A. DATE OF OPERATION <b>1968 J.H.R.</b>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Prostatic obstruction</b>		21C. AUTOPSY? (Yes or No) <b>no</b>	
21D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notably medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from <b>Feb 1968</b> to <b>Jan 22 1969</b> , that (I) (we) last saw the deceased alive on <b>Jan 22 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>George D. Lipsey</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>George D. Lipsey</b>		23D. ADDRESS M.D. <b>426 S. Patterson St. Ar.</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-25-1969</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1969</b>		25B. NAME OF REGISTRAR <b>John E. Jankyn</b>		25C. FUNERAL DIRECTOR <b>Lilly &amp; Zeiler Inc.</b>	
		ADDRESS <b>1901-07 Eastern Ave.</b>			



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-450		69 0819		BALTIMORE CITY HEALTH DEPT		REG. NO. 69 0819	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Phillip L. Allen</i>			
2. DATE AND HOUR OF DEATH <i>1/22/69</i>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>BALTIMORE CITY HOSPITALS</i>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTIMORE</i>			
C. CITY OR TOWN <i>BALTO. MD. 21224</i>				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER <i>9th and CUCKOLD RD. RT 10 BOX 45 F</i>							
5. SEX <i>MALE</i>	6. RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-30-10</i>	9. AGE (In years lost birthday) <i>58</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Assembly man</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Martin Company</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Charles Allen</i>				14. MOTHER'S MAIDEN NAME <i>Agnes Offney</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>BCH RECORDS: 4940 EASTERN AVE. 21224</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>412.4 I</i> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>CVA</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>years</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTO PSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>1/21</i> 19 <i>69</i> to <i>1/22</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>1/22</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Robert H. Brook</i>				23B. DATE SIGNED <i>1/22/69</i>			
23C. PHYSICIAN'S NAME (Type) <i>ROBERT H. BROOK M.D.</i>				23D. ADDRESS <i>BALTIMORE CITY HOSPITALS</i> <i>4940 EASTERN AVE. 21224</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-25-1969</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Rosary</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore County, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 23 1969</i>		25B. NAME OF REGISTRAR <i>Robert H. Brook</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Lilly &amp; Zeiler Inc. 1901-07 Eastern Ave.</i>			





E-163

69 0820 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 0820

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

FRANK EVERETT

2. DATE  
OF DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

1

22

69

10:15 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

January 22,

1969 10:15 a.m.

5. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE

B. COUNTY

Maryland

27-47

6. SEX

Male

7. RACE

White

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

1890

10. AGE (In years  
last birthday)

78

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

6307 Laurelton Ave.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Frank Everett

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Salesman

14B. KIND OF BUSINESS OR INDUSTRY

Sealtest Dairy

15. MOTHER'S MAIDEN NAME

Catherine

?

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

215-10-2399

18. INFORMANT

Marie Everett

ADDRESS

Same

19. DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH(A) IMMEDIATE CAUSE Gunshot wound of the head  
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

6307 Laurelton Ave.

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

1

22

69

?

m.

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Self inflicted wound

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

EXAMINER'S

NAME (Type) Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/22/69

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1/25/69

24C. NAME OF CEMETERY or CREMATORY

Sacred Heart

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 23 1969

25B. NAME OF REGISTRAR

Robert E. Fickema

25C. FUNERAL DIRECTOR

Leonard J Ruck Inc. Baltimore, Maryland

ADDRESS

1999, 2000, 2001)

• • •

2000

1000-1000

90

— 100 + 100

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 69 0821 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

69 0821

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Edna F Chetelat</b>		2. DATE AND HOUR OF DEATH <b>January 22, 1969</b> <b>7A</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 4307 LaSalle Ave</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>26-41</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>4307 LaSalle Ave</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 11, 1898</b>	9. AGE (In years last birthday) <b>70</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Henry Merten</b>		
14. MOTHER'S MAIDEN NAME <b>Ella Snyder</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>216-32-5521</b>			17. INFORMANT <b>Charles W Chetelat</b>		
18. <b>412.31</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>ARTERIOSCLEROTIC Heart Disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Sept 11</b> 19 <b>40</b> to <b>1/22</b> 19 <b>69</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>1/22</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death. 23A. SIGNATURE <b>Albert J Himelfarb</b> 23B. DATE SIGNED <b>1/22/69</b> 23C. PHYSICIAN'S NAME (Type) <b>Albert J Himelfarb M.D.</b> 23D. ADDRESS <b>3501 St Paul St Baltimore, Maryland</b> 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b> 24B. DATE <b>1/25/69</b> 24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer</b> 24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b> 25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1969</b> 25B. NAME OF REGISTRAR <b>Robert E. Johnson</b> 25C. FUNERAL DIRECTOR <b>Leonard J Ruck Inc. Baltimore, Maryland</b> 25D. ADDRESS					

10

10-10-41

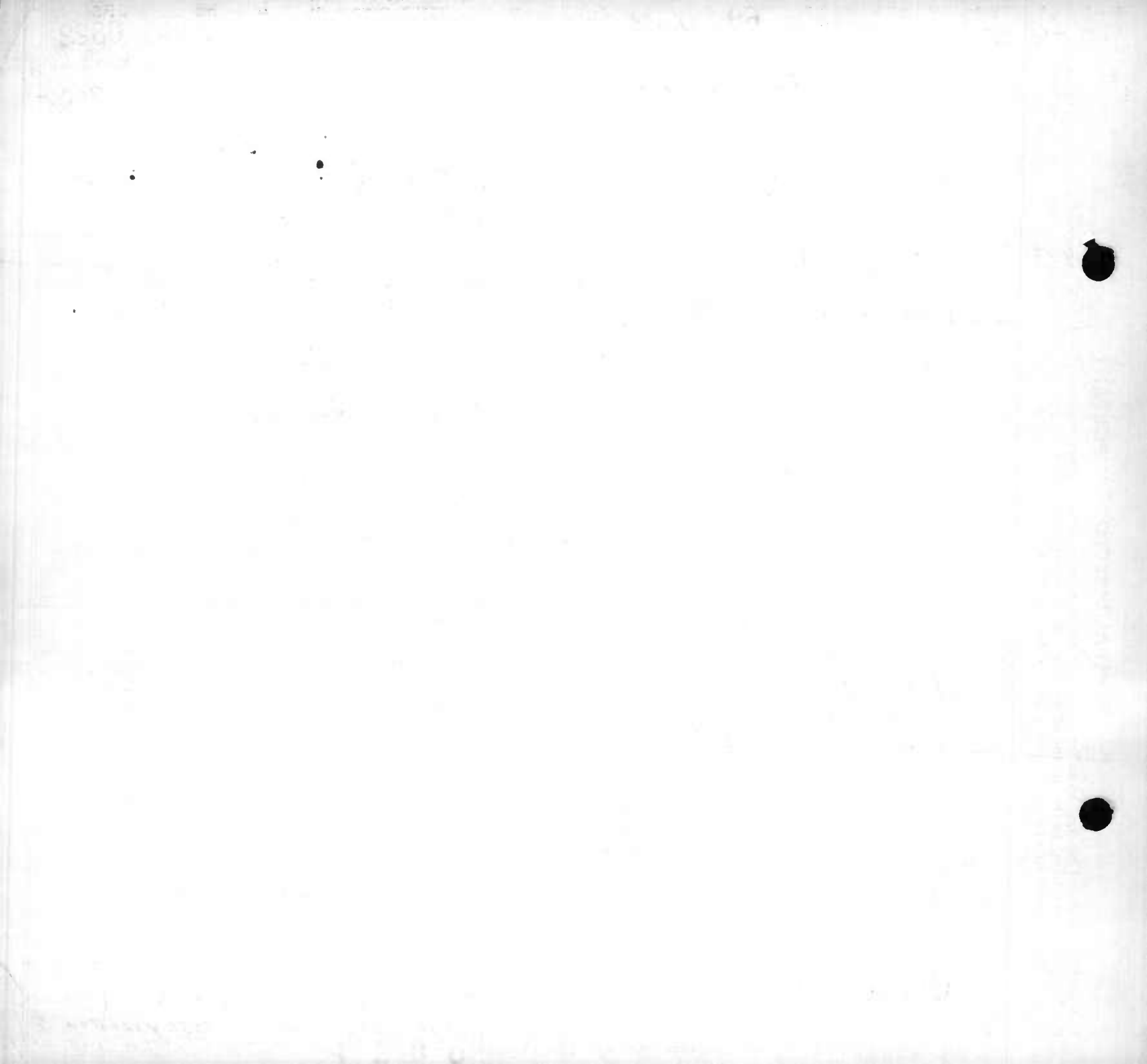
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10-10-41

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0822		BALTIMORE CITY HEALTH DEPARTMENT		L NS		69 0822	
BIRTH NO.		CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print)		Dean Flohr				2. DATE AND HOUR OF DEATH 1/22/69 300 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Pa. B. COUNTY YORK V-35					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University Hospital 38		C. CITY OR TOWN Dillsbury		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER 127 W York St.							
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/13/30	9. AGE (In years last birthday) 38	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Business		10B. KIND OF BUSINESS OR INDUSTRY Travel Agcy.		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bradley Flohr		14. MOTHER'S MAIDEN NAME Mabel Furich		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes Korea			
16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records				ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF: Brain				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min	
		(B) Hemorrhage into Extensive Glioblastoma, DUE TO, OR AS A CONSEQUENCE OF:				3 mos	
		(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 1/18/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Br. Tumor		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1/14/69 19 to 1/22/69 19 that (I) (we) last saw the deceased alive on 1/21/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Frederick K. Grossman, Jr., MD		23B. DATE SIGNED 1/22/69		23C. PHYSICIAN'S NAME (Typal)		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-24-1969		24C. NAME of CEMETERY or CREMATORY Dillsburg Cemetery		24D. LOCATION (City, town, or county) (State) Dillsburg York Co. Penna	
25A. DATE REC'D BY HEALTH DEPT. JAN 23 1969		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Wm. Cook & Sons, Inc.		ADDRESS 1050 York Rd Towson, Md 21204	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0823

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

69 0823

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>CHARLES C. COLEMAN</b>		2. DATE AND HOUR OF DEATH <b>January 17, 1969 11:38 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>THE UNION MEMORIAL HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>9-06</b>		
			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>1813 E. 33rd. St.</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/5/1885</b>	9. AGE (In years last birthday) <b>83</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Bank clerk</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE</b>	
12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>		13. FATHER'S NAME <b>FRANKLIN P. COLEMAN</b>			
14. MOTHER'S MAIDEN NAME <b>SARAH ANN WEBER</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY NO. <b>216-09-4279</b>		17. INFORMANT <b>CHART. Mrs. Christine D. Coleman</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute myocardial Infarction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic cardiovascular disease</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Diabetes Mellitus</b>			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>II</b>					
21A. DATE OF OPERATION <b>2/10/69</b>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR?	
23A. TIME OF INJURY (APPROX.)		23B. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		23C. HOW DID INJURY OCCUR?	
24. I certify that (I) (this hospital) attended the deceased from <b>January 16 1969</b> to <b>January 17 1969</b> , that (I) (we) last saw the deceased alive on <b>January 17 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
25A. SIGNATURE <b>Cesar A. Bravo</b>				25B. DATE SIGNED <b>1/17/69</b>	
26A. PHYSICIAN'S NAME (Type) <b>CESAR A. BRAVO</b>				26B. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>	
27A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		27B. DATE <b>1/20/69</b>		27C. NAME of CEMETERY or CREMATORY <b>Druid Ridge Cem.</b>	
27D. LOCATION <b>Balto. County, Md.</b>		27E. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1969</b>			
27F. NAME OF REGISTRAR <b>R. A. E. Fabela</b>		27G. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home</b>			
27H. ADDRESS <b>6500 York Rd. 21212</b>					

THE NEW MEMORIAL HOSPITAL

X

MADE WHITE

RETIRED

FRANKLIN F. COLEMAN

1812 E 34th ST

11/2/1957

DALLAS

24th AND WALKER

CHARTER

January 16, 1957

11/1/57

UNION MEMORIAL HOSPITAL

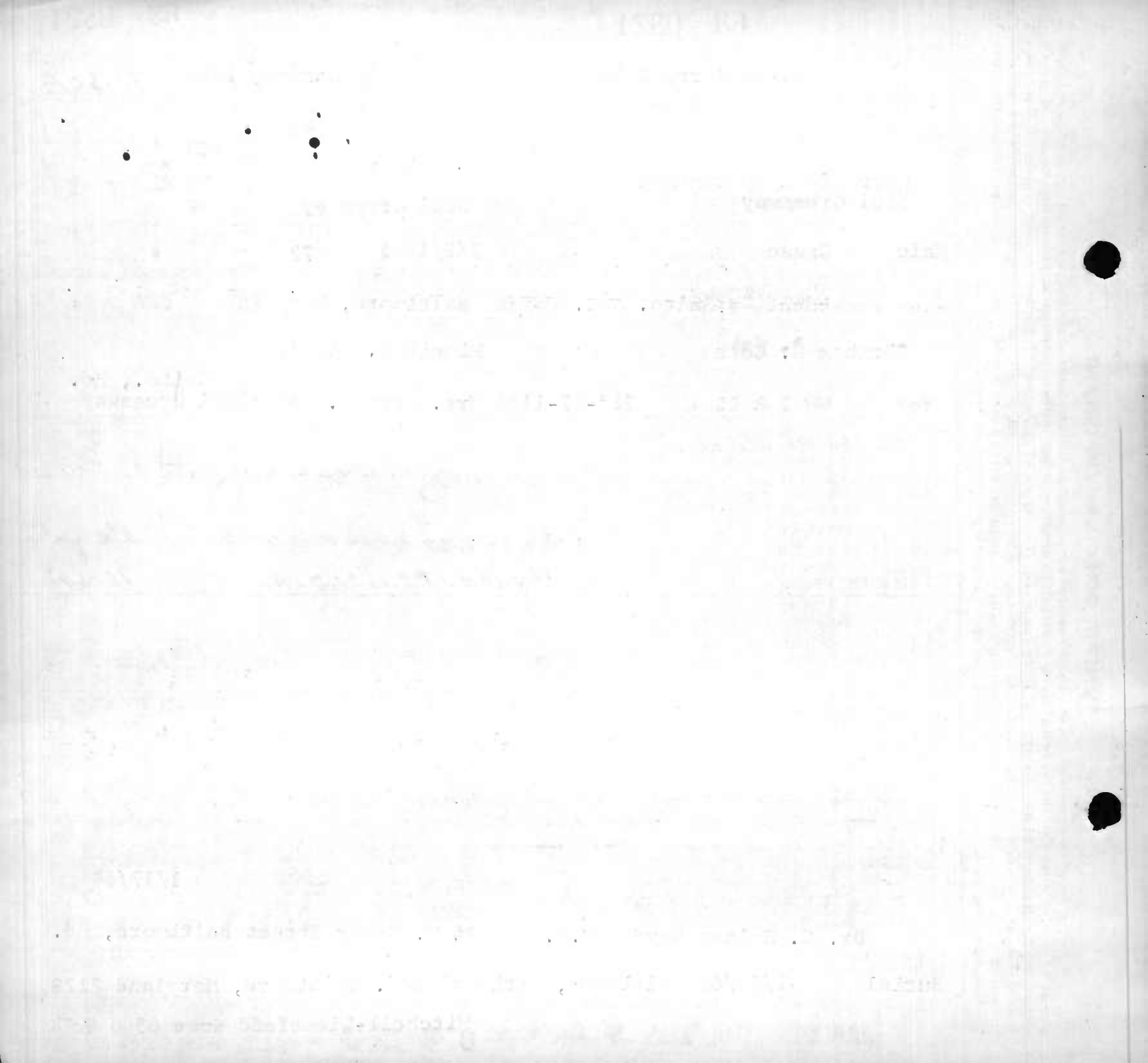
CEGAR & BRAND



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 0824	
BIRTH NO.		69 0824		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Edwin Harry Cole</b>			2. DATE AND HOUR OF DEATH <b>17 January 1969 7:30 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Carrollton Apartments 3601 Greenway</b>			A. STATE <b>Maryland</b> B. COUNTY <b>12-01</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>3601 Greenway</b>		
5. SEX <b>Male</b>	6. RACE <b>Caucas</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/2/1895</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Vice President (Ret)</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Balto. Bus. Forms</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Abraham G. Cole</b>			
14. MOTHER'S MAIDEN NAME <b>Minnie G. Dickle</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW I &amp; II</b>			
16. SOCIAL SECURITY NO. <b>215-07-1184</b>		17. INFORMANT ADDRESS <b>Balto., Md. Mrs. Mary M. Cole 3601 Greenway</b>			
18. <b>410.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Myocardial infarct</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Hypertension</b>		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 min</b> <b>10 yrs</b> <b>11 yrs</b>					
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>October 6 1958</b> to <b>January 17 1969</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>January 13 1969</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE <b>C. Holmes Boyd</b>				23B. DATE SIGNED <b>1/17/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. C. Holmes Boyd M.D.</b>				23D. ADDRESS <b>24 E. Eager Street Baltimore, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/20/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore, National Cem. Baltimore, Maryland 2128</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1969</b>		25B. NAME OF REGISTRAR <b>John E. Fadden</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Mitchell-Wiedefeld Home 6500 York Rd. Balto., Md. 21212</b>	



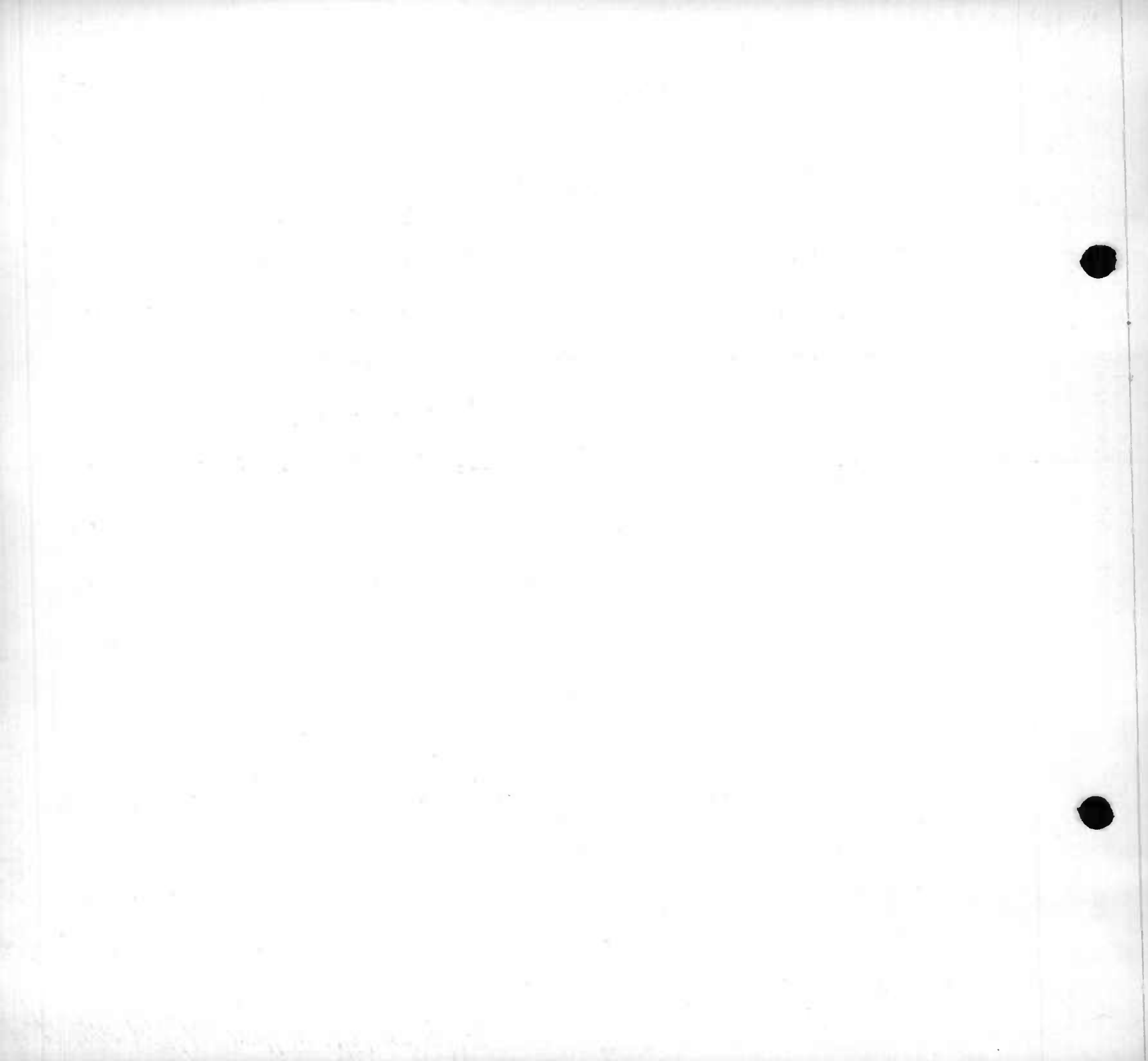
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 69 0825 CERTIFICATE OF DEATH

REG. NO. 69 0825

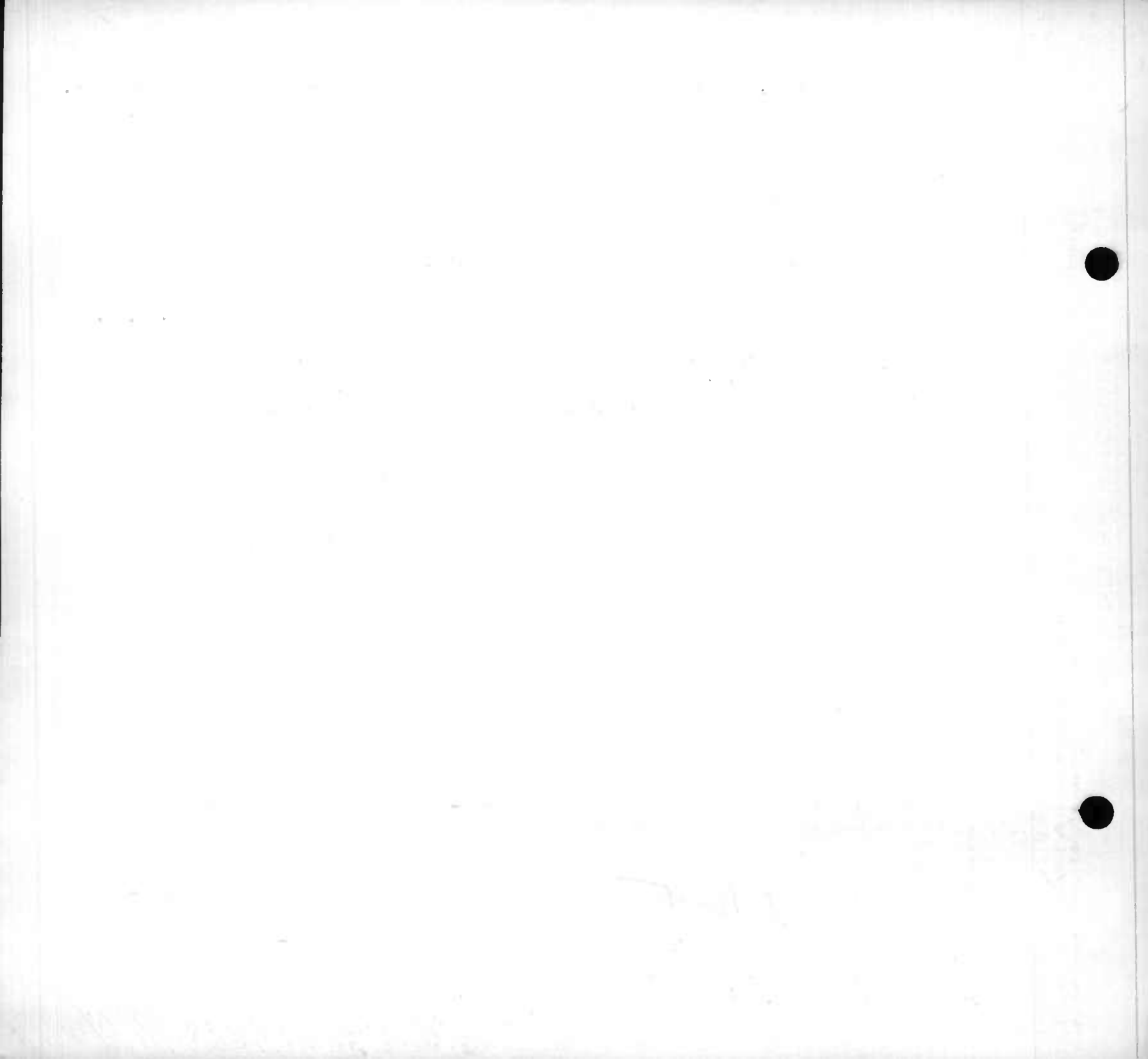
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Raymond Ware, Sr.</u>		2. DATE AND HOUR OF DEATH <u>11/19/69</u> <u>6:20</u> P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>17-03</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>University of Md. Hospital</u> <u>38</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>725 George St., Apt 10A</u>		5. SEX <u>M</u>		6. RACE <u>N</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/6/00</u>		9. AGE (In years lost birthday) <u>68</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>MD. Balto.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Unknown. Raymond Ware</u>		14. MOTHER'S MAIDEN NAME <u>Unknown. Sadie Harris</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unkn.</u>		16. SOCIAL SECURITY NO. <u>Unkn.</u>		17. INFORMANT <u>Emergency Room Chart</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiorespiratory Failure</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinomatosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>&lt; 30 min.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Ca. of Stomach</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>2 yrs.</u>		(C) DUE TO, OR AS A CONSEQUENCE OF: <u>2 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>1967</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ca of Stomach</u>		20A. AUTOPSY? (Yes or No) <u>Yes (Abdom)</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Ca of Stomach</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Yes</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>9 AM 11/19 1969</u> to <u>6:20 PM 11/19 1969</u> that (1) (we) last saw the deceased alive on <u>11/19 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John M. Steffy MD</u>		23B. DATE SIGNED <u>11/19/69</u>		23C. PHYSICIAN'S NAME (Type) <u>John M. Steffy MD</u>	
23D. ADDRESS <u>University Hospital Baltimore, Md</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/24/69</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>William E. Steffy</u>		24D. LOCATION <u>Balto. Md</u>		24E. NAME OF REGISTRAR <u>Robert E. Steffy</u>	
24F. DATE REC'D BY HEALTH DEPT. <u>11/24/69</u>		24G. NAME OF REGISTRAR <u>Robert E. Steffy</u>		24H. FUNERAL DIRECTOR <u>William E. Steffy</u>	
24I. ADDRESS <u>399 Scholander St</u>		24J. ADDRESS <u>399 Scholander St</u>		24K. ADDRESS <u>399 Scholander St</u>	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 0826	
BIRTH NO. 69 0826		CERTIFICATE OF DEATH		REG. NO. 69 0826	
1. NAME OF DECEASED (Type or Print) Suggs, Webster		2. DATE AND HOUR OF DEATH 1-19-69 9:40 a. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 Provident Hospital 1514 Division Street Baltimore, Maryland		A. STATE Maryland B. COUNTY 14-02 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1628 McCulloh Street			
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-15-25	9. AGE (In years last birthday) 43	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Henry Suggs		14. MOTHER'S MAIDEN NAME Cecile ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 244-20-6368		17. INFORMANT Alice Suggs (wife) 129 McPhail	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Chronic Myeloma		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic Renal Failure		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-25-68 19 to 1-19-69 19 that (I) (we) last saw the deceased alive on 1-19-69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Virginia Y. Fausto, M.D.		23B. DATE SIGNED 1-20-69			
23C. PHYSICIAN'S NAME (Type) VIRGINIA Y. FAUSTO, M.D.		23D. ADDRESS Provident Hospital 1514 Division Street- Maryland, Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/20/69		24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem. Balto Md.	
24D. LOCATION (City, town or county) (State)		25A. DATE REC'D BY HEALTH DEPT. JAN 23 1969		25B. NAME OF REGISTRAR Robert E. Jackson, M.D.	
25C. FUNERAL DIRECTOR		25D. ADDRESS		25E. SIGNATURE	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

69 0821

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Hodsdon, Andrew</i>		2. DATE AND HOUR OF DEATH <i>1-19-69</i> <i>9:55 P. M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>16-03</i>		C. CITY OR TOWN <i>Balto.</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Duke Land Nursing Home</i> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>1501 Duke Land St. Balto, Md. #21216</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <i>1627 Edmondson Ave</i>	
5. SEX <i>m</i>	6. RACE <i>N</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-12-95</i>	9. AGE (In years last birthday) <i>73</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>HonFolk, VA</i>	
13. FATHER'S NAME <i>Josuha Hodsdon</i>		14. MOTHER'S MAIDEN NAME <i>Nancy Hunter</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>213-32-8220</i>		17. INFORMANT <i>Duke Land Nursing Home</i> ADDRESS <i>1501 Duke Land St.</i>	
18. <i>427.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pneumonia, acute</i> (B) <i>Constrictive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>8-13-18</i> to <i>1-18-1969</i> , that (I) (we) last saw the deceased alive on <i>1-18-1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Perceval C. Smith</i>		DEGREE <i>MD</i>		23B. DATE SIGNED <i>1-20-69</i>	
23C. PHYSICIAN'S NAME (Type) <i>Perceval C. Smith MD</i>		23D. ADDRESS <i>4200 Edmondson Ave.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>1-23-69</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Catholic National Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 23 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>William Phillips</i> ADDRESS <i>1727 N. Monmouth</i>	

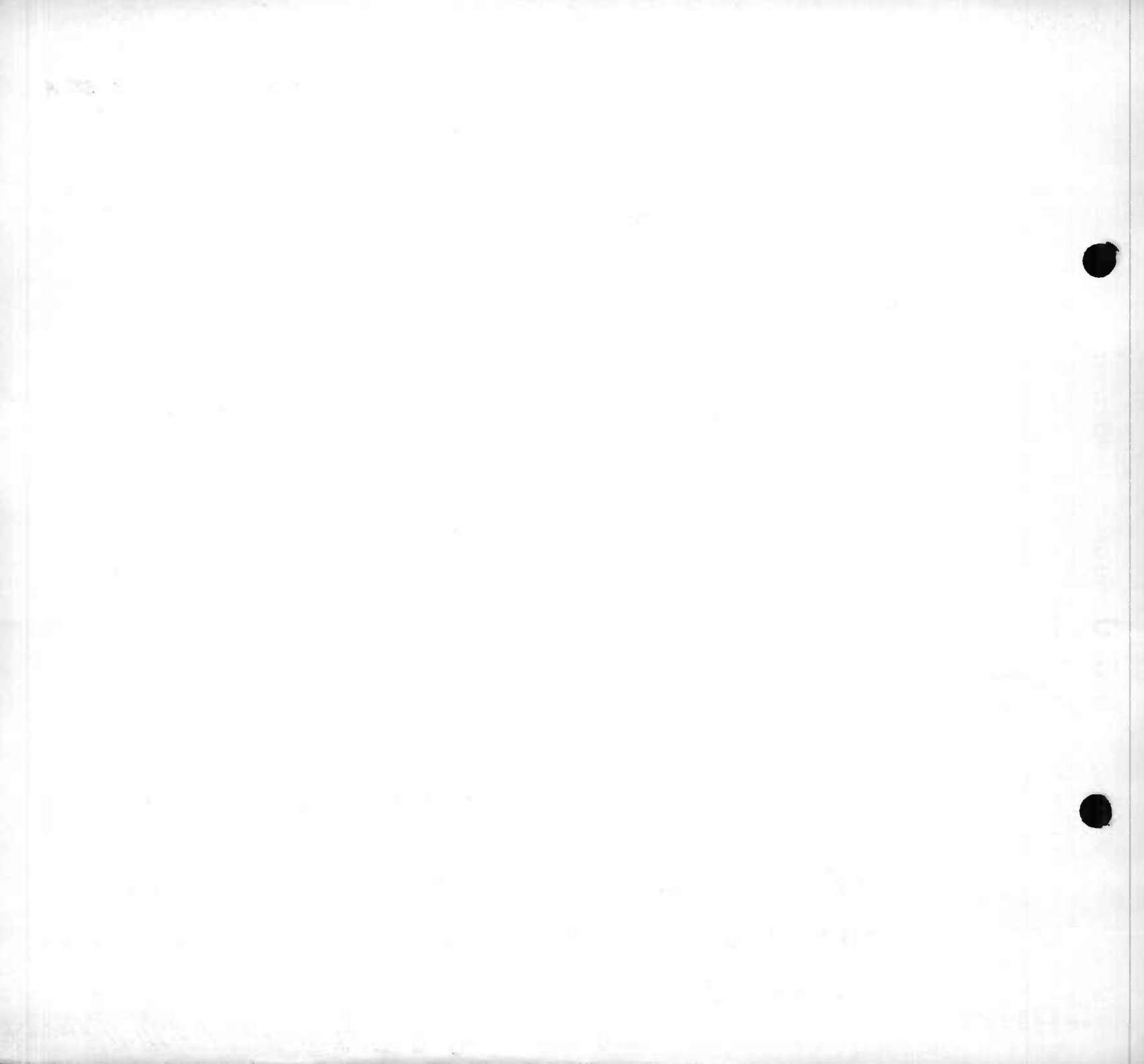
ALLEN & BOND



# FUNERAL DIRECTOR: IMPORTANT

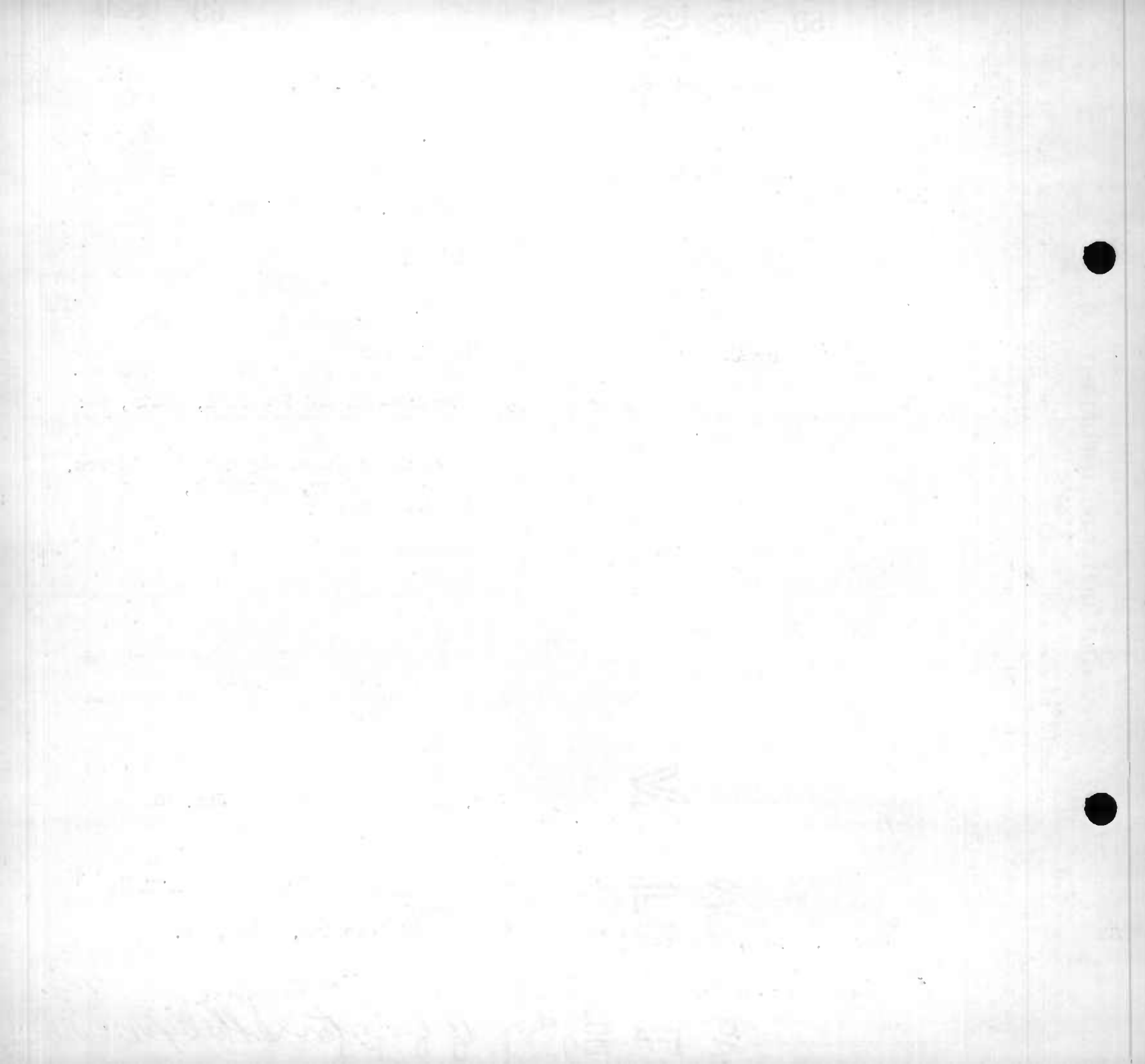
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
69 0828		69 0828		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		WOOD ANTHONY		1/20/69 3:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			MARYLAND 15-12		
UNIVERSITY OF MARYLAND 38 HOSPITAL SEPARATED			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX MALE			6. RACE COLORED		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
FORK LIFT OPER.				4/9/24	
13. FATHER'S NAME DANIEL WOOD		14. MOTHER'S MAIDEN NAME LUCY BARKSDALE		9. AGE (in years last birthday) 47	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-12-5703		17. INFORMANT MILDRED BOVCAH	
				ADDRESS 2804 HILLDALE AVE BALTO. MD.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last			CAUSE OF DEATH CARCINOMA OF SPINE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  CARCINOMA OF PROSTATE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/15 1968 to 1/20 1969 that (I) (we) last saw the deceased alive on 1/20 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE T. Alvero				23B. DATE SIGNED 1/20/69	
23C. PHYSICIAN'S NAME (Type) THOMAS ALVERO M.D.				23D. ADDRESS UNIVERSITY OF MARYLAND HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1-23-69		Mt. Calvary	
25A. DATE REC'D BY HEALTH DEPT. JAN 23 1969		25B. NAME OF REGISTRAR R. E. J. J.		25C. FUNERAL DIRECTOR Wilmington Phillips	
				ADDRESS 1727 N. Mount.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

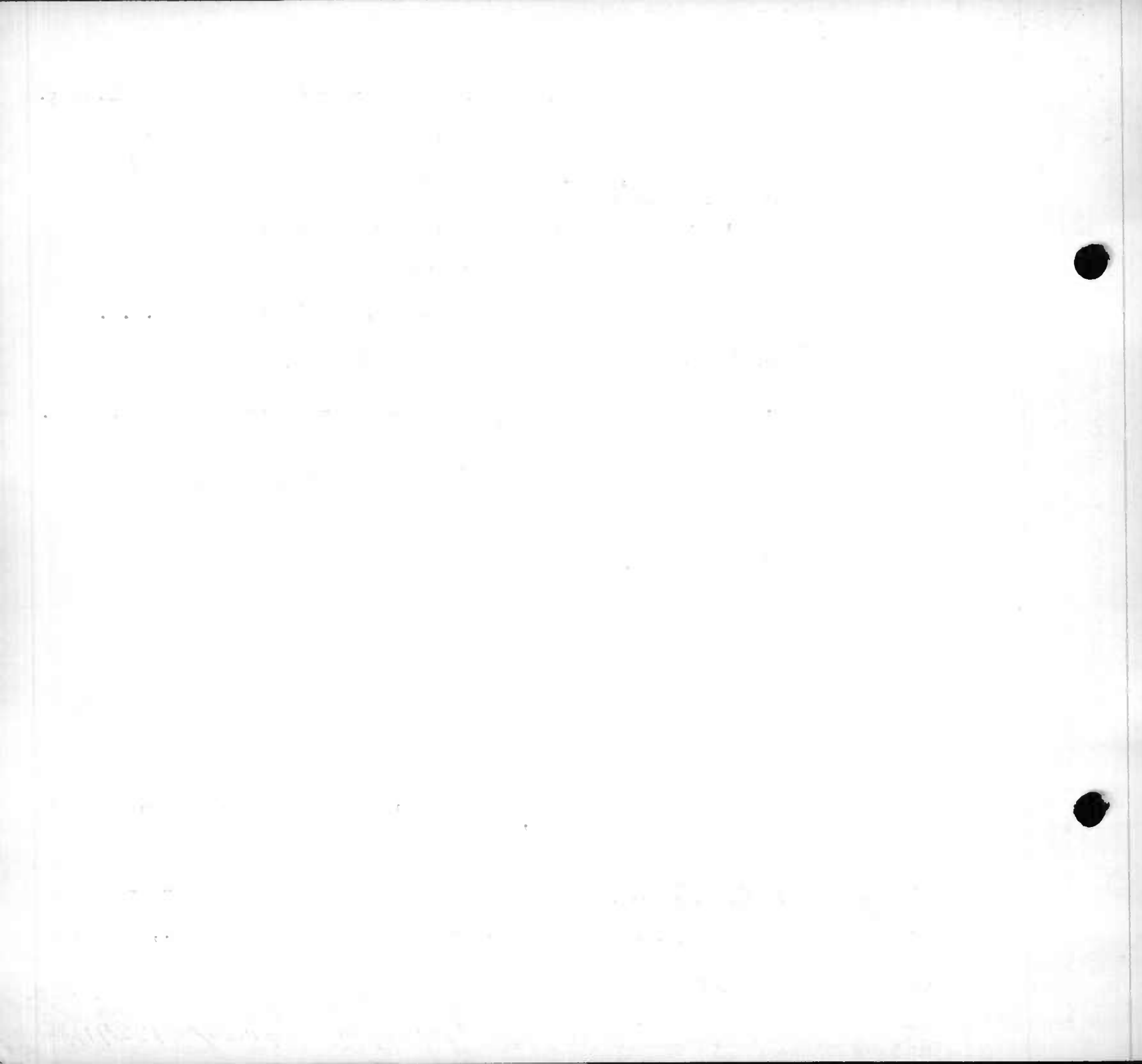
T 460 1		69 0829		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 0829	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)			
				Blanche Hazel Taylor			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				Md. 16-05			
US Public Health Service Hospital 3100 Wyman Parkway				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1237 N. Bentalou Street			
5. SEX F	6. RACE col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/7/07	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic work			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Frank Burrell			14. MOTHER'S MAIDEN NAME Novella Fox				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 220-05-5021		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma involving the liver, extensive, probably primary (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 mos.	
MEDICAL CERTIFICATION							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan. 11 19 69 to Jan. 21 19 69, that (I) (we) last saw the deceased alive on Jan. 21 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Henry S. Crist, M.D.				23B. DATE SIGNED 1/21/69		23C. PHYSICIAN'S NAME (Type) Henry S. Crist, Surgeon (R)	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1-25-69		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 23 1969		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Delington Shell		ADDRESS 2211 N. ... St.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <b>69 0830</b>	
BIRTH NO. <b>69 0830</b>		1. NAME OF DECEASED (Type or Print) <b>Mary Richardson RICKSON</b>		2. DATE AND HOUR OF DEATH <b>1-18-69 1:45 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>39 Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217</b>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-02</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1800 Monroe Street</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-19-89</b>	9. AGE (In years last birthday) <b>79</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-32-18456</b>		17. INFORMANT <b>Synette Taylor- Niece</b> ADDRESS <b>1820 Monroe St.</b>	
18. <b>43391</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <b>Coronary Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>December 22, 1968</b> to <b>January 18, 1969</b> that (I) (we) last saw the deceased alive on <b>January 18, 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Virginia Y. Lausto, M.D.</b> DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>1-18-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>VIRGINIA Y. LAUSTO</b> DEGREE		23D. ADDRESS <b>1514 Division Street Balto., Maryland</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1-21-69</b>	24C. NAME of CEMETERY or CREMATORY <b>Ashburton Memph.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR <b>Wilmington Sheller</b> ADDRESS <b>1727 N. Mount</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 69 0831 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

69 0831

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

EURIPIDES G. PAPACHRISTOU

2. DATE AND HOUR OF DEATH

January 19, 1969 10:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

26-05

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

630 Umbra Street

5. SEX

Male

6. RACE

White

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

3-15-15

9. AGE (In years last birthday)

53

10. Under 1 Yr. Months Days

11. Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Owner-Salesman

10B. KIND OF BUSINESS OR INDUSTRY

Coffee and Tea

11. BIRTHPLACE (State or foreign country)

Waterloo, Iowa

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George Papachristou

14. MOTHER'S MAIDEN NAME

Evadni Garifalis

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

330-14-1652

17. INFORMANT

Mrs. Betty Papachristou

ADDRESS

630 Umbra St., Baltimore Md.

18. 63291

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

Extensive coronary occlusion

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1/2 hr.

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

Duodenal Ulcer

6-1/2 years

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED While At ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Aug 16, 1967 to Jan 19, 1969, that (I) (we) lost saw the deceased alive on Jan 19, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M. B. Levin M.D.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

Jan 21, 1969

23C. PHYSICIAN'S NAME (Type)

M. B. Levin, M. D.

23D. ADDRESS

218 E. University Parkway, Balto. Md. 21218

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1-22-69

24C. NAME of CEMETERY or CREMATORY

Greek Orthodox Cemetery Baltimore, Md.

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 23 1969

25B. NAME OF REGISTRAR

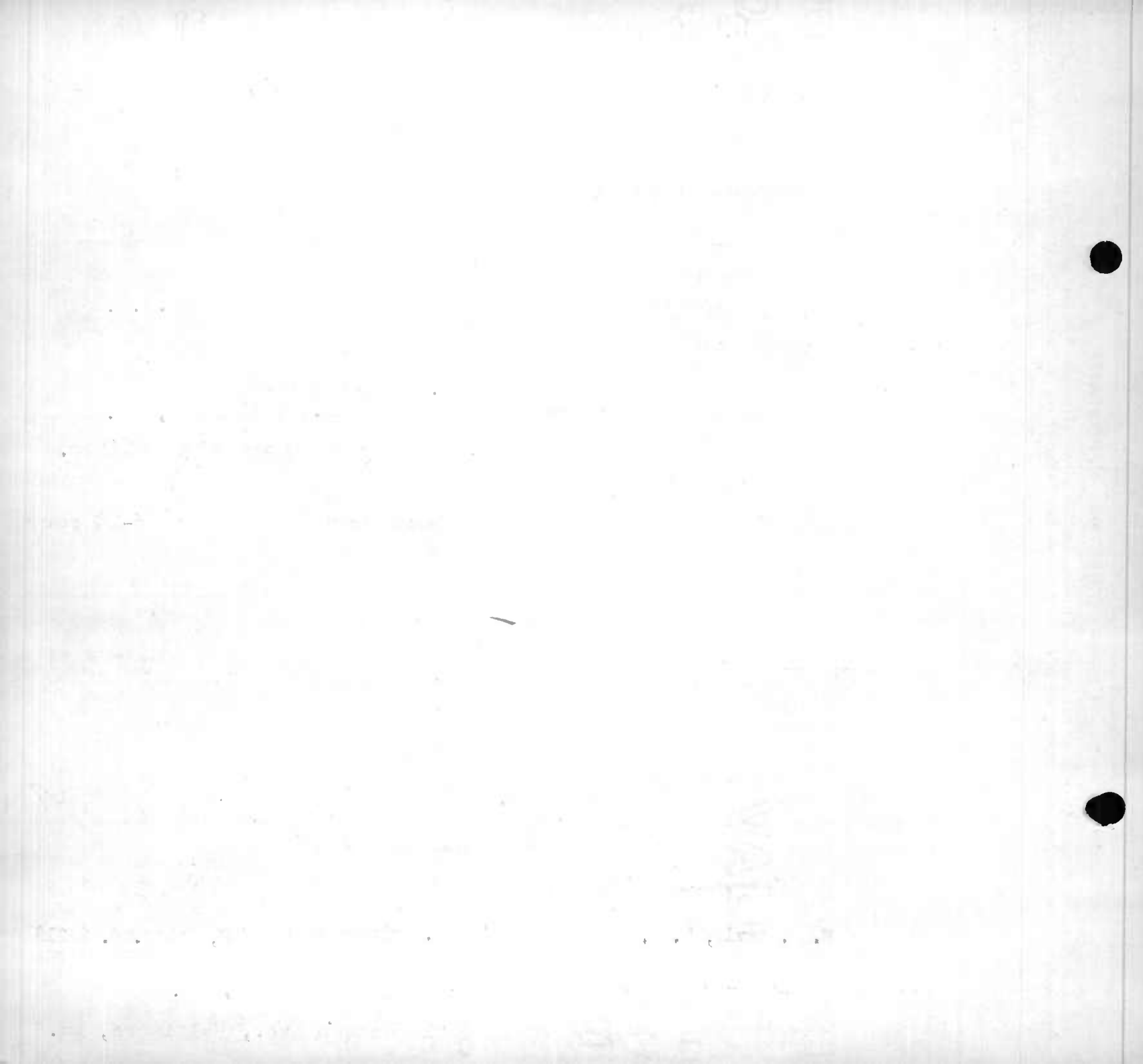
Robert E. Jenkins

25C. FUNERAL DIRECTOR

Nicholas T. Matthews

ADDRESS

302 Eastern Ave., Baltimore, Md.

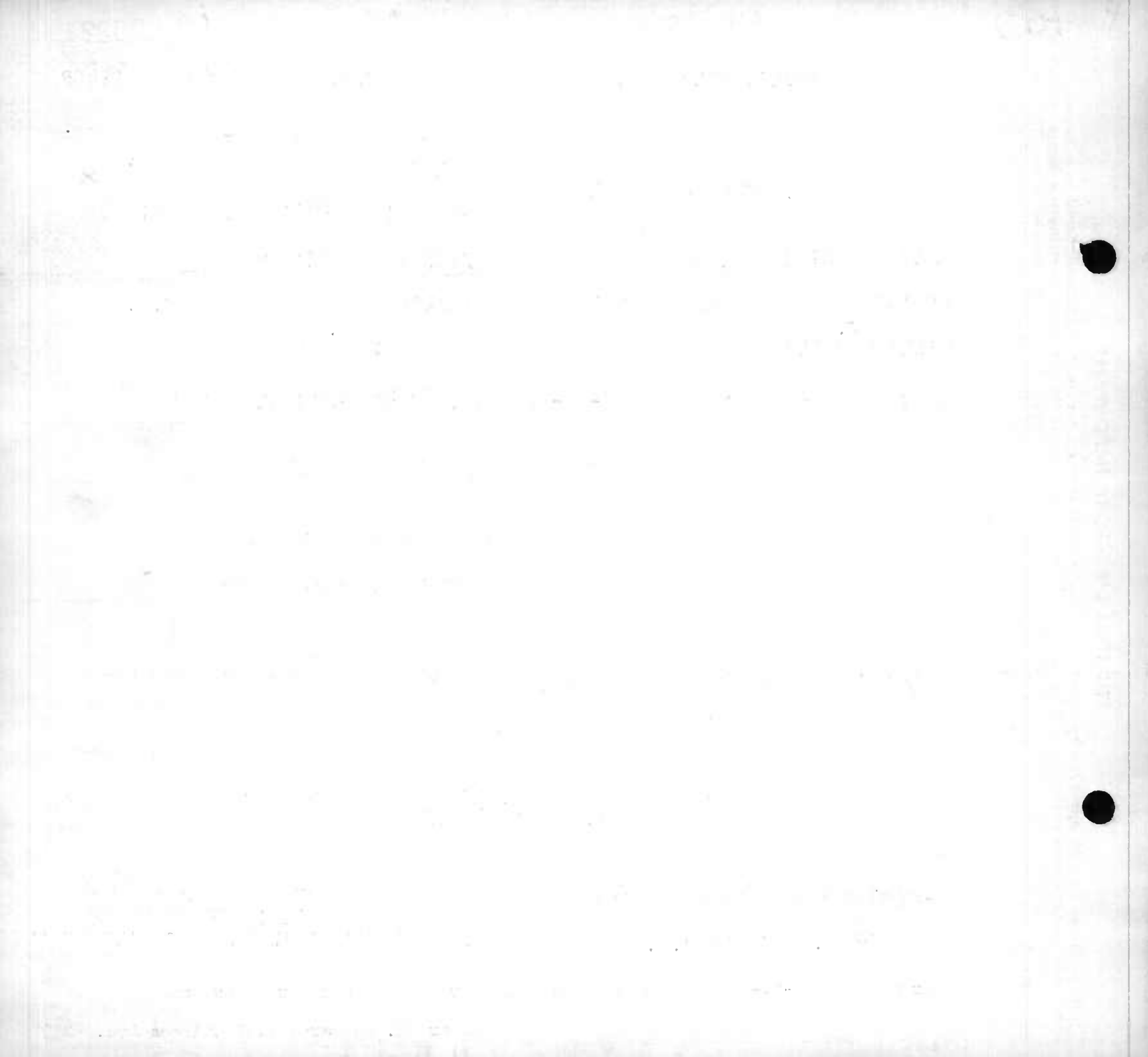




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		69 0832		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 0832	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
POOLE, ROLAND C.				JANUARY 21, 1969 3:40P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
ST. AGNES HOSPITAL				MARYLAND Baltimore 53-00			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER			
				408 MAIDEN CHOICE LANE 21228			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	01/16/02	67			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
RETIRED		MAINTENANCE		MARYLAND		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
WILLIAM POOLE				MARY MAX POOLE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NONE		216-03-4279		ST. AGNES HOSPITAL RECORDS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ACUTE MYOCARDIAL INFARCTION							
RESTRICTIVE AIRWAY DISEASE							
SEVERE PULMONARY EMPHYSEMA							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
1/18/69		LUNG CANCER		NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
NO							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from JANUARY 2 1969 to JANUARY 21 1969 that (I) (we) last saw the deceased alive on JANUARY 21 1968 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Frank M. Detorie M.D.				1/21/69			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
FRANK M. DETORIE M.D.				BALTIMORE, MD 21229			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial				1-24-1969		New Cathedral Cemetery	
25A. DATE RECEIVED BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 23 1969				Robert E. Hubbard		Howard H. Hubbard, 4107 Wilkens Ave. 21229	



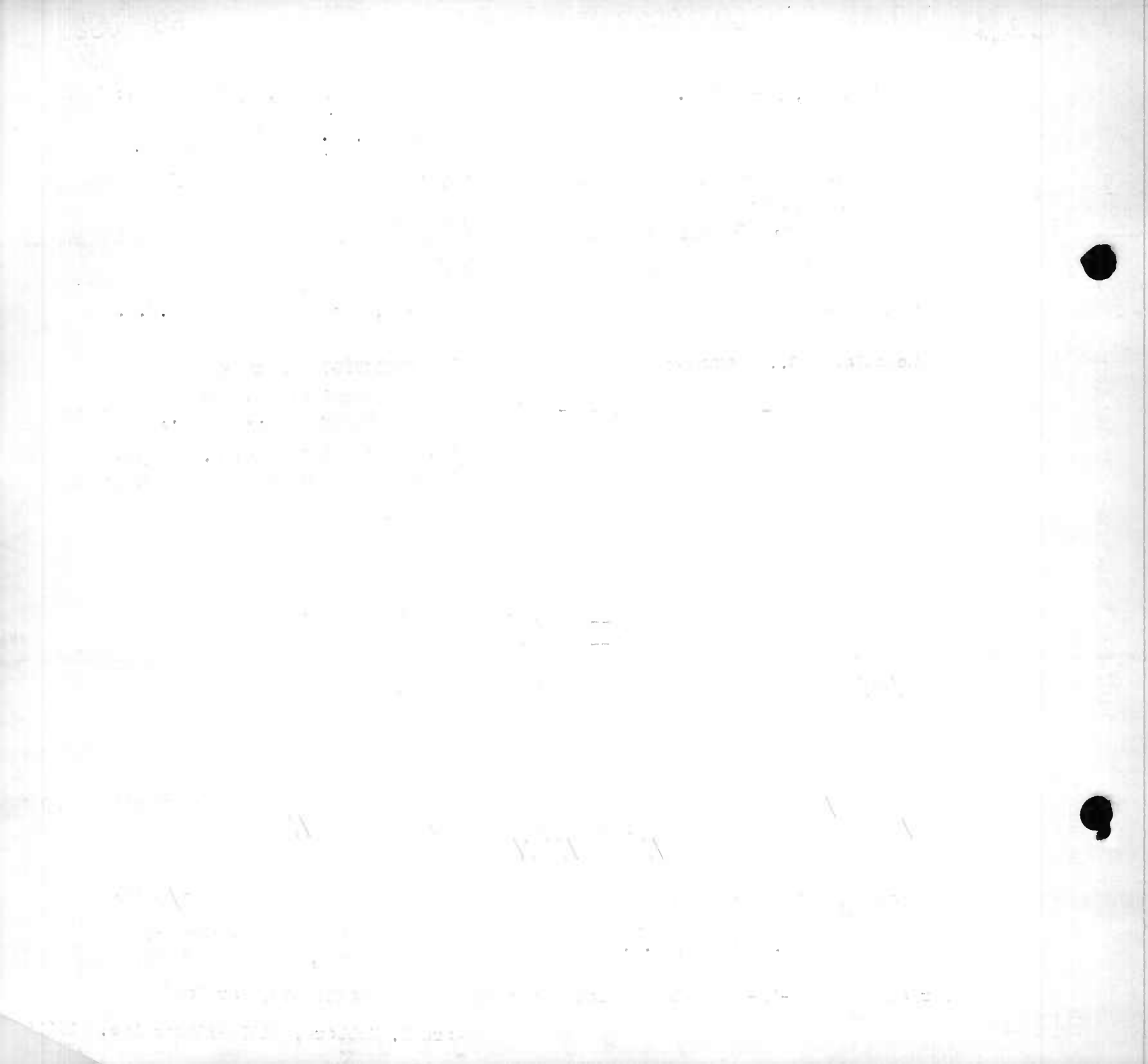
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0833 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO.

69 0833

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>HARRISON, Herbert E.</b>		2. DATE AND HOUR OF DEATH <b>January 22, 1969 7:52 A M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>25-51</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>3714 Benson Avenue</b>					
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/3/90</b>	9. AGE (In years last birthday) <b>78</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Blacksmith</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Zedekiah J. Harrison</b>		14. MOTHER'S MAIDEN NAME <b>Alice Sherbert</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 7/25/18 - 5/12/19</b>		16. SOCIAL SECURITY NO. <b>216-01-2389</b>		17. INFORMANT <b>VA Hospital Records</b> <b>3900 Loch Raven Blvd., Balto., Md 21218</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>1 Malignancy involving lungs.</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Primary site unknown</b> DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Greater than one month</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>		1. Generalized arteriosclerosis 2. Emphysema			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>1/21/69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Thoracentesis</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>December 27th 1968</b> to <b>January 22nd 1969</b> that (I) (we) last saw the deceased alive on <b>January 22nd 1969</b> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>George W. Gaffney</b>		DEGREE <b>Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/></b>		23B. DATE SIGNED <b>1/22/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>GEORGE W. GAFFNEY, M.D.</b>		23D. ADDRESS <b>3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-25-69</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Starkey</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>	
ADDRESS <b>4107 Wilkens Ave. 21229</b>					



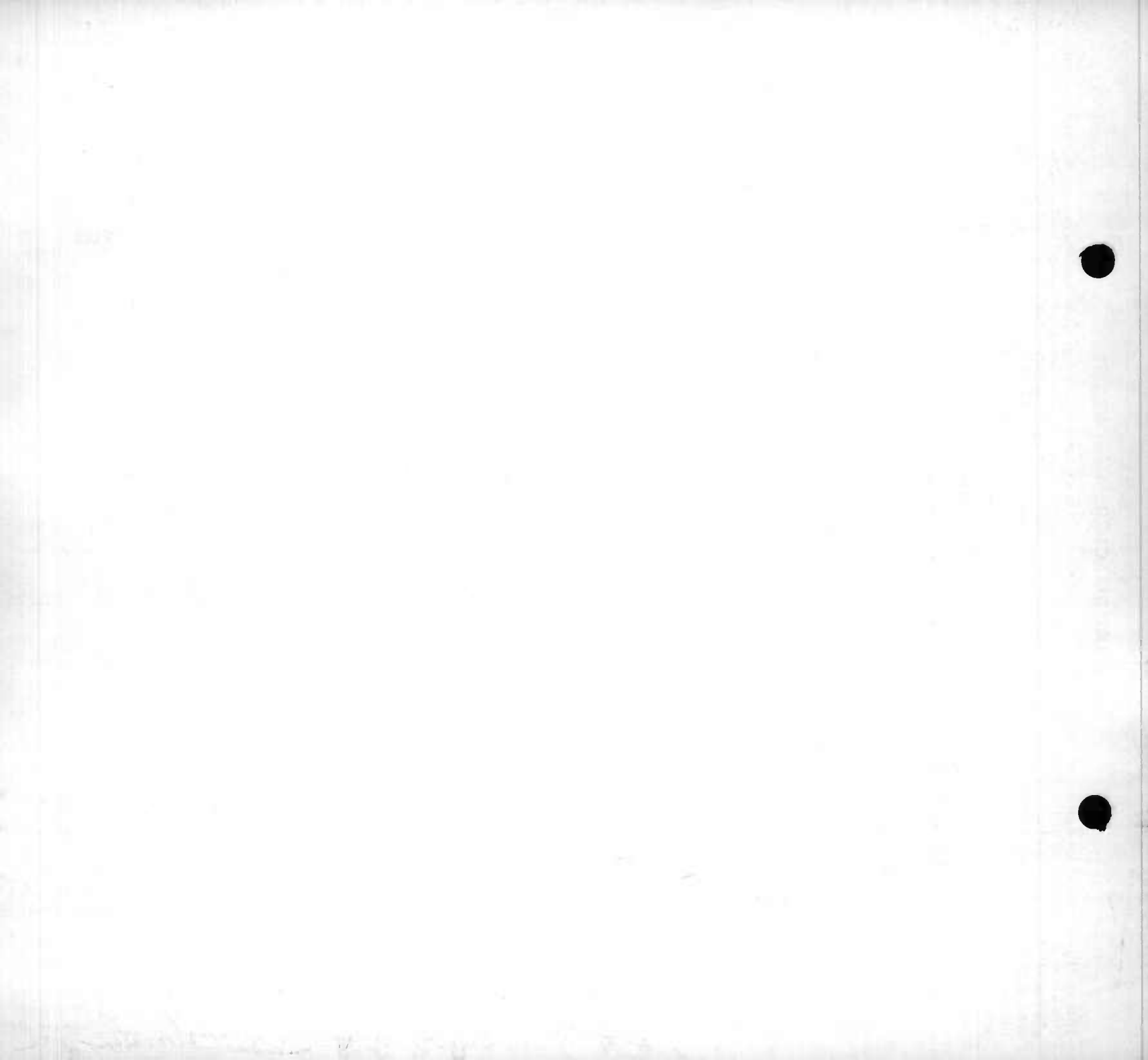
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0834

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 0834

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>McCray, Daisy</u>		2. DATE AND HOUR OF DEATH <u>7-21-69</u> <u>940</u> p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University of Md. Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence below admission) A. STATE <u>md.</u> B. COUNTY <u>21-01</u>		C. CITY OR TOWN <u>Baltimore</u>	
5. SEX <u>Fem</u>		6. RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>office work</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md.</u>	
13. FATHER'S NAME <u>Venton Jennings</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Holland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Patient's chart</u>	
18. <u>174 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (At stating the UNDERLYING CONDITION lost.)  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Pneumo thorax</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Bilateral Thorocentesis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Hydrothorax 2° metastatic breast</u> <u>Carcinoma</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1-2 Hrs</u> <u>2-3 Hrs</u> <u>1; 3 yrs</u>	
19A. DATE OF OPERATION <u>7-21-69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Bilat. Hydrothorax</u>		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, ship, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1-20</u> 19 <u>69</u> to <u>1-21-</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>1-21-</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Rolf Nieman MD</u>		23B. DATE SIGNED <u>1-21-69</u>		23C. PHYSICIAN'S NAME (Type) <u>R. If Nieman</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-25-69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>McCray Cent</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 23 1969</u>		25B. NAME OF REGISTRAR <u>James S. [unclear]</u>		25C. FUNERAL DIRECTOR <u>Elmer Wilson 1000 Briantley Ave</u>	
24D. LOCATION (City, town, or county) (State) <u>A A County Md</u>		25D. ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0835 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 69 0835

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Finch, Mrs. Lucille</b>		2. DATE AND HOUR OF DEATH <b>1-21-69</b> <b>2:45pm</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Baltimore, Maryland</b> B. COUNTY <b>13-07</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Keswick Nursing Home</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>700 West 40th Street</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Female</b>		6. RACE <b>C</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chesapeake &amp; Potomac</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Telephone Company</b>		8. DATE OF BIRTH <b>5-9-66</b> 9. AGE (In years last birthday) <b>40</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Alex Jackson</b>	
14. MOTHER'S MAIDEN NAME <b>Florence Wilson</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-10-5084</b>	
17. INFORMANT <b>Mary B. DiPaula R.N</b>		ADDRESS <b>Keswick</b>		18. CAUSE OF DEATH	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Paralytic Ileus</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Scleroderma</b>	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Hypertensive Cardiovascular Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>11 yrs</b>		21. MEDICAL CERTIFICATION	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9 May 1966</b> to <b>21 Jan 1969</b> , that (I) (we) last saw the deceased alive on <b>21 Jan 1969</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dr. A. Richardson</b>				23B. DATE SIGNED <b>21 JAN 1969</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. A. Richardson</b>		23D. ADDRESS <b>Keswick</b>		23E. MEDICAL DIRECTOR <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys.	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-25-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Antebellum</b>	
24D. LOCATION (City, town, or county) (State) <b>Lanham Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>E. Gray R. Skiles</b>		ADDRESS <b>3101</b>		25D. MEDICAL DIRECTOR <b>Dr. A. Richardson</b>	

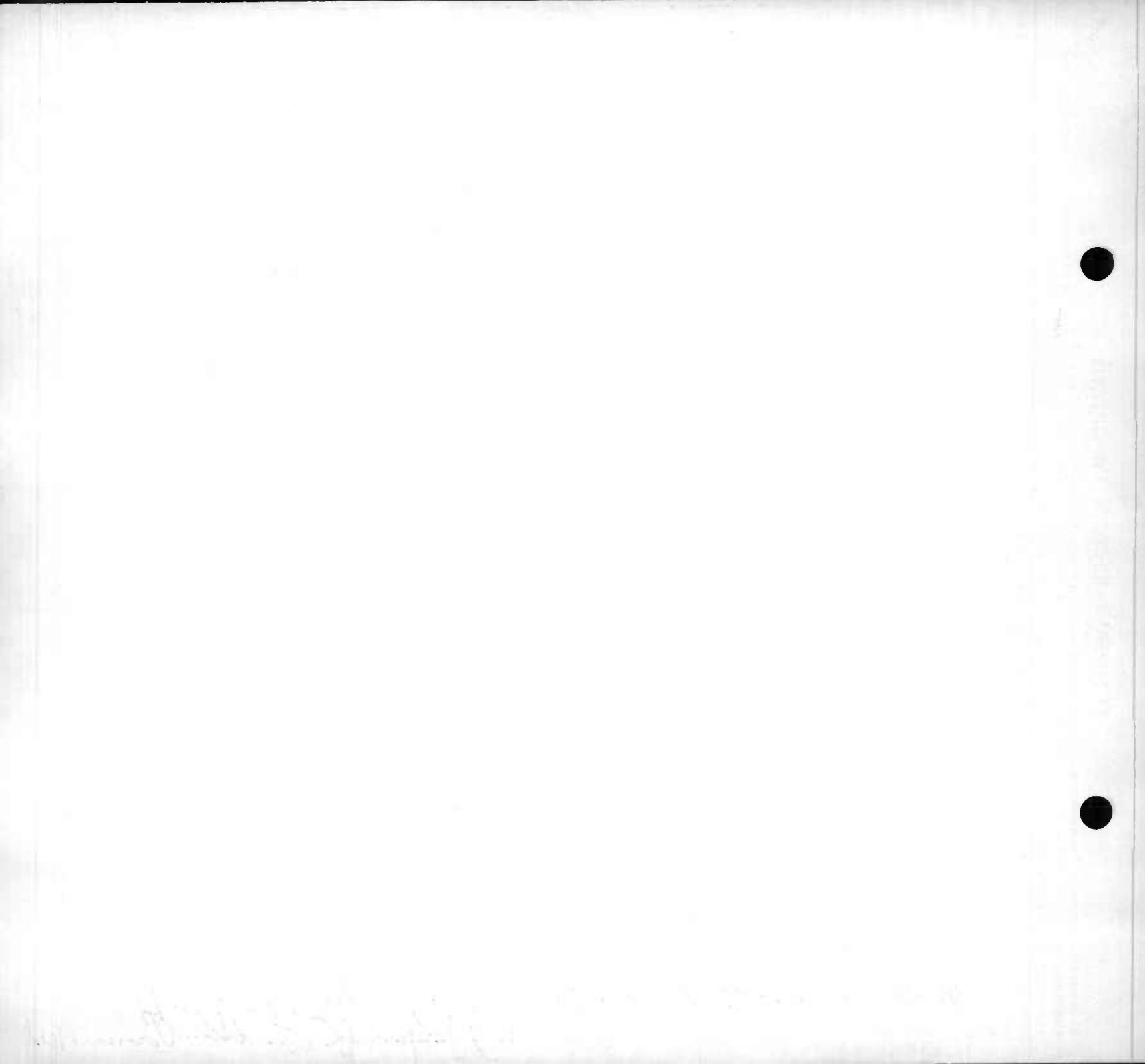
3rd 10/10/10



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">69 0836</span>	
BIRTH NO. <span style="font-size: 1.2em;">69-04142 69 0836</span>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">BABY GIRL PRINGLE</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">1/21/69</span> <span style="font-size: 1.5em;">8:10 AM</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">MERCY HOSPITAL</span>		A. STATE <span style="font-size: 1.2em;">MARYLAND</span>		B. COUNTY <span style="font-size: 1.2em;">A.A. Co.</span>	
		C. CITY OR TOWN <span style="font-size: 1.2em;">GLEN BURNIE</span>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <span style="font-size: 1.2em;">484 MOL PARK DRIVE</span>			
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <span style="font-size: 1.2em;">1/21/69</span>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years lost birthday) <span style="font-size: 1.2em;">6</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">DOUGLAS PRINGLE</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">ELIZABETH NASON</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">USA</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">PT'S CHART</span>	
18. <span style="font-size: 1.2em;">777X I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <span style="font-size: 1.2em;">PREMATURITY</span> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">NO</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">1/21/69</span> to <span style="font-size: 1.2em;">1/21/69</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">1/21/69</span> and that (n) (my) (our) apinlan death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Esther Edery M.D.</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">1/21/69</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">ESTHER EDERY</span>		23D. ADDRESS <span style="font-size: 1.2em;">MERCY HOSPITAL</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">CREMATION</span>		24B. DATE <span style="font-size: 1.2em;">1.2.26.69</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">LONDON PARK CREMATORY</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">BALTIMORE MD.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JAN 23 1969</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">J. J. [Signature]</span>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
WILLIAM NEAL SIEBOLD		1-21-69 7:15		P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
44 UNION MEMORIAL		MARYLAND BALT 27-44			
		C. CITY OR TOWN BALT		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3409 ELENORE AVE			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-20-07	9. AGE (In years last birthday) 61	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHOTOGRAPHY		10B. KIND OF BUSINESS OR INDUSTRY PHOTOGRAPHY		11. BIRTHPLACE (State or foreign country) OHIO	
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME FRED SIEBOLD		14. MOTHER'S MAIDEN NAME BLANCHE NEAL	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT WIFE CLARA SIEBOLD. SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: VENTRICULAR FIBRILLATION (B) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 MIN 1 MONTH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-14 1968 to 1-21 1969, that (I) (we) last saw the deceased alive on 1-20-69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Francis X. Carmody		23B. DATE SIGNED 1-21-69			
23C. PHYSICIAN'S NAME (Type) FRANCIS X. CARMODY		23D. ADDRESS 3201 N CHARLES			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/24/69		24C. NAME OF CEMETERY or CREMATORY ST. MATTHEW'S	
24D. LOCATION BALTIMORE MD		24E. NAME OF REGISTRAR JAN 24 1969		24F. FUNERAL DIRECTOR GREGORY FUNERAL HOME - 4210 BELMONT	

12-30-80

THE UNIVERSITY OF CHICAGO



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0838

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

69 0838

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*Katherine M. Kelly*

2. DATE AND HOUR OF DEATH

*Jan. 20, 1969*

*11P* M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

*504 Tunbridge Road*

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

*Maryland*

C. CITY OR TOWN

*Baltimore*

E. STREET AND NUMBER

*504 Tunbridge Road*

D. INSIDE CITY LIMITS?

YES ☐

NO ☐

5. SEX

*Female*

6. RACE

*White*

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

*3/17/1894*

9. AGE (In years last birthday)

*74*

If Under 1 Yr. Months: Days

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Housewife*

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

*Ireland*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

*William Hanly*

14. MOTHER'S MAIDEN NAME

*Mary Shiel*

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

*No*

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*Mr. John J. Kelly 504 Tunbridge Rd.*

18. *401X I*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

*Hypertensive Vascular Disease*

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

*years*

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from *5/24* 19*57* to *1/20* 19*69*, that (I) (we) last saw the deceased alive on *1/20* 19*69* and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

*Attending Physician*

DEGREE

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

*1/20/69*

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

DEGREE

24A. BURIAL CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*1/24/69*

24C. NAME of CEMETERY or CREMATORY

*Baltimore National Cemetery Baltimore, Maryland*

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

*JAN 24 1969*

25B. NAME OF REGISTRAR

*John A. Moran, Inc.*

25C. FUNERAL DIRECTOR

*John A. Moran, Inc. 3000 E. Baltimore St.*

ADDRESS

11/11/11  
11/11/11

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11/11/11

11/11/11

11/11/11

**FUNERAL DIRECTOR: IMPORTANT**

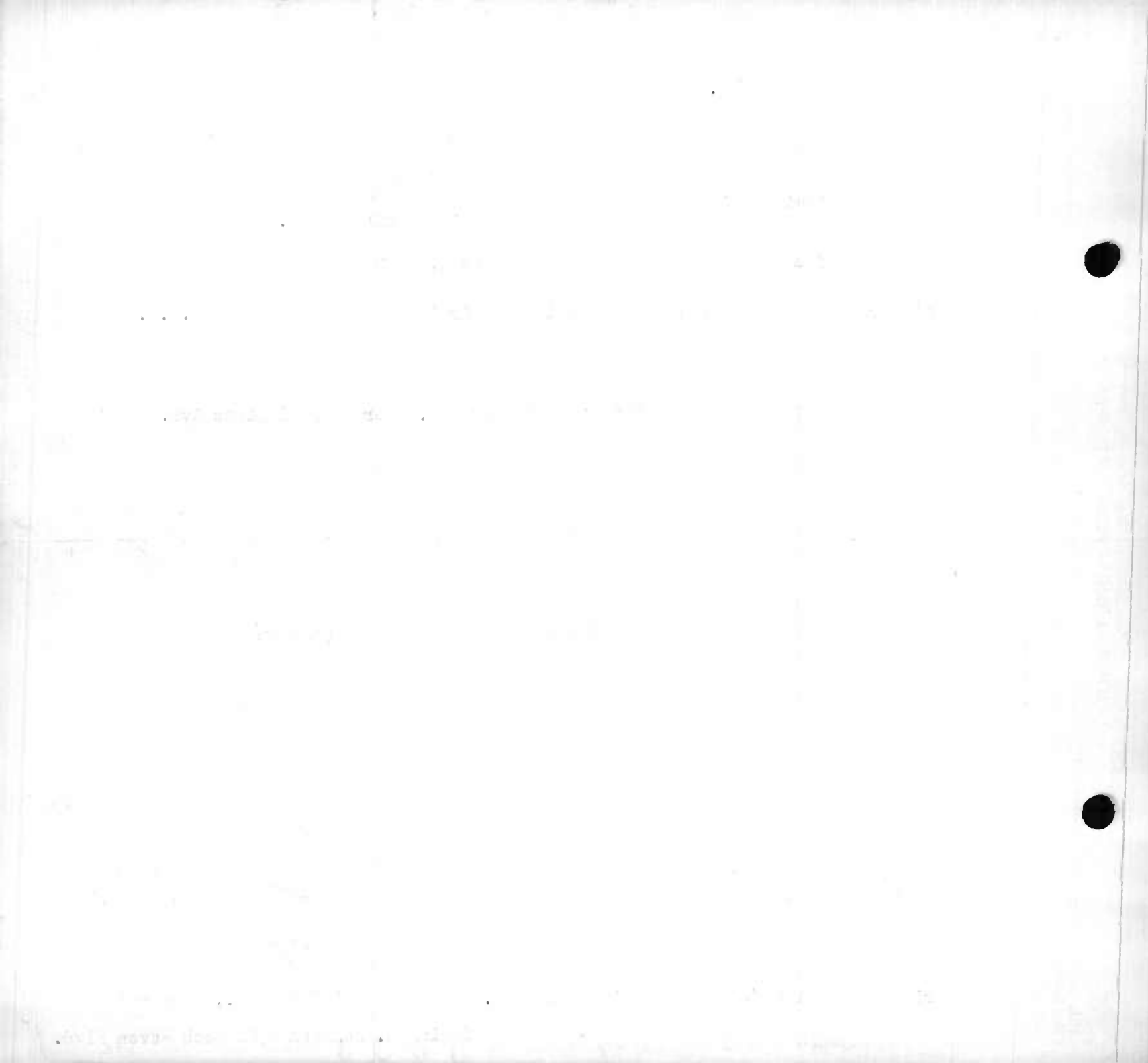
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0839 BALTIMORE CITY HEALTH DEPARTMENT

**CERTIFICATE OF DEATH**

REG. NO. 69 0839

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Howard E. Geer</u>		2. DATE AND HOUR OF DEATH <u>1-18-69</u> <u>9:38 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <u>42</u> <u>Sinai Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>15-10</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3821 Garrison Blvd.</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1, 1892</u>	9. AGE (In years last birthday) <u>76</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Home Improvement</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>212 12 5313</u>		17. INFORMANT ADDRESS <u>Ferol E. Geer 1519 Williams Ave. 21221</u>	
18. <u>579.2</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Bronchopneumonia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCUD, chronic alcoholic</u>		(B) <u>C.O.P.D.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If only medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from <u>1-16</u> 19 <u>69</u> to <u>1-18</u> 19 <u>69</u> that (X) (we) last saw the deceased alive on <u>1-18</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>M. Florenstein</u> DEGREE				23B. DATE SIGNED <u>1/18/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>Sinai Hosp.</u> DEGREE				23D. ADDRESS <u>Baltimore Co., Maryland</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/22/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Co., Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 24 1969</u>			
25B. NAME OF REGISTRAR <u>William E. Johnson</u>		25C. FUNERAL DIRECTOR ADDRESS <u>8521 Loch Raven Blvd.</u>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0840

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

69 0840


BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) AUDREY K. OBERDORFF		1/21/69 19:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205		PENNYSYLVANIA C. CITY OR TOWN WRIGHTSVILLE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX FEMALE		6. RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-24-13	
9. AGE (In years last birthday) 55		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CLYDE W. NUNN		14. MOTHER'S MAIDEN NAME KATHERINE WOOD	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 187 10 8736	
17. INFORMANT G. K. Oberdorff		ADDRESS 316 N. 4th. Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Brain stem decompensation (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Post-operative hemorrhage (B) DUE TO, OR AS A CONSEQUENCE OF: pharyngeal adenoma (C) Subtotal resection of pharynx		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min. 21 hr. 24 hr.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 20 Jan 69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED pharyngeal adenoma	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 15 Jan 1969 to 21 Jan 1969 that (I) (we) lost saw the deceased alive on 21 Jan 1969 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Lawrence F. Jelsma		23B. DATE SIGNED 21 Jan 69	
23C. PHYSICIAN'S NAME (Type) LAWRENCE F. JELSMA M.D.		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/25/69	
24C. NAME of CEMETERY or CREMATORY Mt. Rose Cem.		24D. LOCATION (City, town, or county) (State) York Co., Penna.	
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1969		25B. NAME OF REGISTRAR G. E. Johnson	
25C. FUNERAL DIRECTOR Wm. E. Johnson		ADDRESS 8521 Loch Raven blvd. 21204	

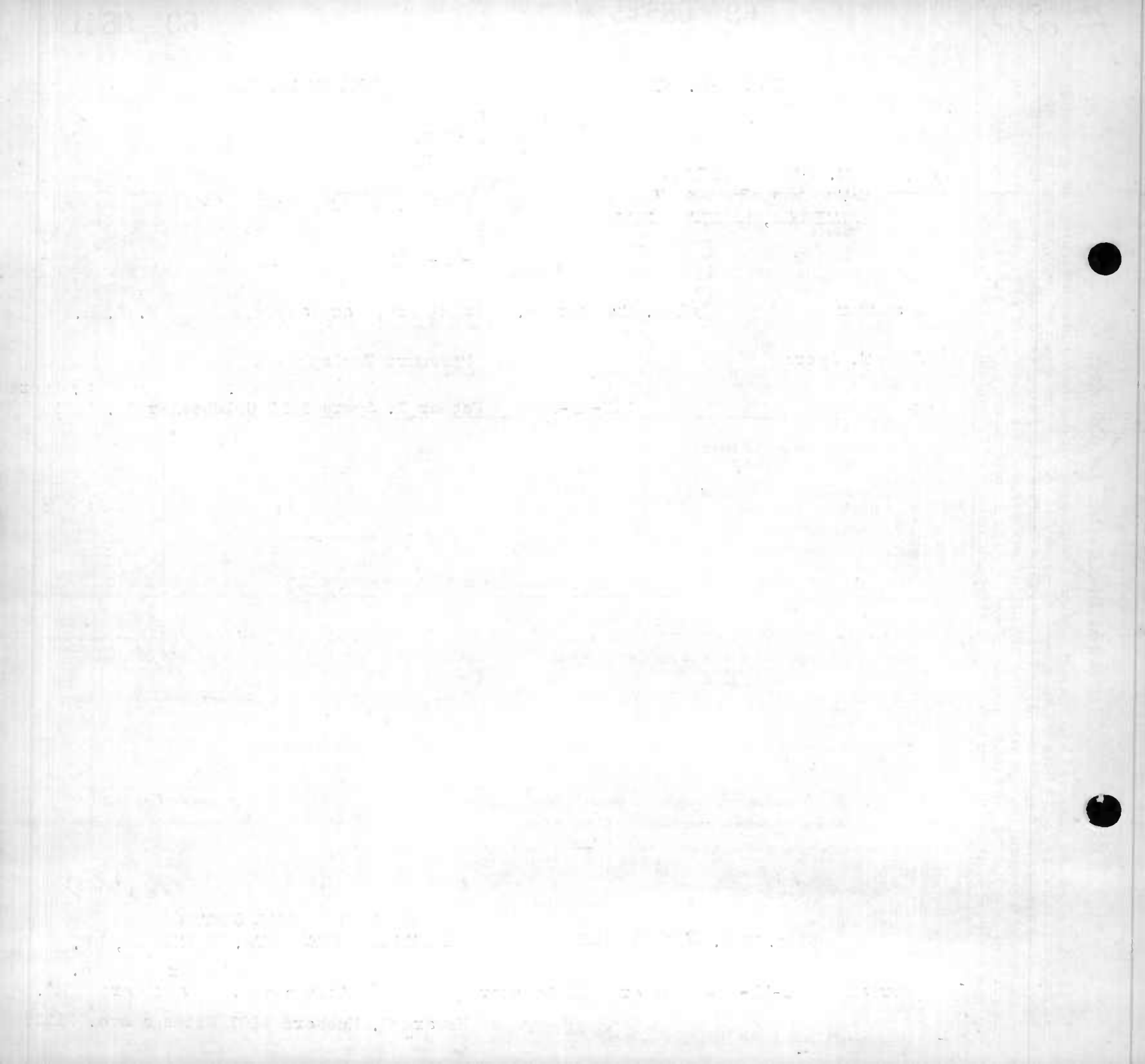
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151 01 151

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>69 0841</b>
69 0841				CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		
		<b>WILLIAM H. AYERS</b>		
2. DATE AND HOUR OF DEATH		JANUARY 23, 1969 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST. AGNES HOSPITAL CATON AND WILKENS AVENUES BALTIMORE, MARYLAND 21229</b>		MARYLAND		<b>25-51</b>
		C. CITY OR TOWN <b>BALTIMORE</b>		
5. SEX M <input checked="" type="checkbox"/> W <input type="checkbox"/>		6. RACE W <input checked="" type="checkbox"/> N <input type="checkbox"/>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Balto. Transit Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>
13. FATHER'S NAME <b>John T. Ayers</b>		14. MOTHER'S MAIDEN NAME <b>Missouri Rowley</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-05-5898</b>		17. INFORMANT <b>Esther R. Ayers 3932 Colchester Rd. 21229</b>
18. <b>441-21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) <b>ISCVD</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ISCVD</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Abd. aortic aneurysm</b>		(B) <b>Previous coronary occlusion</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Abd. aortic aneurysm</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Abd. aortic aneurysm post op</b>				
19A. DATE OF OPERATION <b>12/21</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Abd. aortic aneurysm</b>		20A. AUTOPSY? (Yes or No) <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input type="checkbox"/>
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <input type="checkbox"/>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <input type="checkbox"/>
22. I certify that (I) (this hospital) attended the deceased from <b>Dec 26</b> 19 <b>67</b> to <b>Present</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>12/21</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) ( <del>did</del> ) (did not) view the body after death.				
23A. SIGNATURE 		23B. DATE SIGNED <b>1/23/69</b>		23C. PHYSICIAN'S NAME (Type) <b>Elliott R. Fishel RKN</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-27-69</b>		24C. NAME of CEMETERY or CREMATORY <b>Cedar Hill Cemetery</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1969</b>		25B. NAME OF REGISTRAR <b>Howard H. Hubbard</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard 4107 Wilkens Ave. 21229</b>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0842 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 69 0842

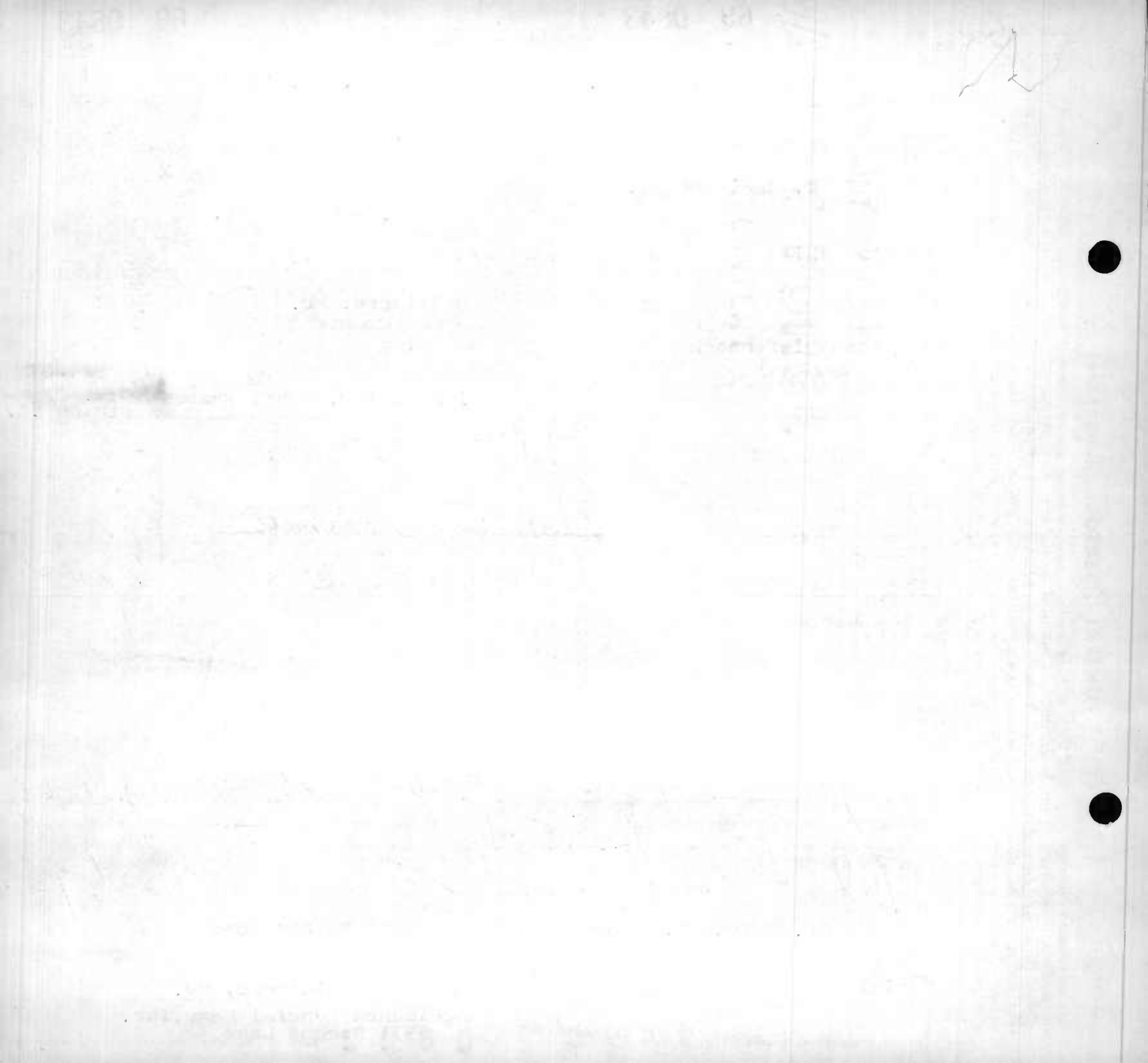
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ALBERT J. BACH, SR.		January 22, 1969 745/A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
00 4126 Walrad Road Baltimore, Maryland			Maryland		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			4126 Walrad Road Ave 21229		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10-28-1899	69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Machine Operator		Glass		Baltimore, Maryland	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
Jacob J. Bach			U. S. A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		213-05-2972		Joseph J. Bach 408 Rosecroft Terrace	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II			MASSIVE MYOCARDIAL INFARCTION		2 MIN.
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			A.C.U.H.D		5 YRS.
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 2-6 1961 to 1-22 1969, that (I) (we) last saw the deceased alive on 1-14 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Dr. John F. Schaefer				1/22/69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. John F. Schaefer				410 Random Road, Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1-25-69		New Cathedral Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Balto. City, Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 24 1969		Howard H. Hubbard		ADDRESS	
				Howard H. Hubbard, 4107 Wilkens Ave. 21229	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 0843	
<div style="display: flex; justify-content: space-between;"> <span>39 0843</span> <span>CERTIFICATE OF DEATH</span> </div>					
BIRTH NO. 15		1. NAME OF DECEASED (Type or Print) <b>CHRISTIANNA (ANNA) W. MATTSON</b>		2. DATE AND HOUR OF DEATH <b>Jan. 21, 1969</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>00 530 N. Robinson St.</b>		A. STATE <b>Md. 21205</b>		B. COUNTY <b>7-01</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>530 N. Robinson St.</b>			
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/30/93</b>	9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind at work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Adam Diefenbach</b>		14. MOTHER'S MAIDEN NAME <b>Mina</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mina Keeley, dght, above</b>	
				ADDRESS <b>530 N. Robinson St.</b>	
18. <b>1829 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>INTERBROCK OBSTRUCTION</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <b>Interbrock Obstruction</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Interbrock Carcinoma</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Carcinoma of Uterus</b> (C) <b>6 years</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>October 19 52</b> to <b>January 21 19 69</b> , that (I) (we) last saw the deceased alive on <b>January 17 19 69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Melvin F. Polek, M.D.</b>		23B. DATE SIGNED <b>1/23/69</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. Melvin F. Polek</b>	
23D. ADDRESS <b>3603 Belair Road</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>1/25/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>	
				ADDRESS <b>3331 Brehms Lane</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

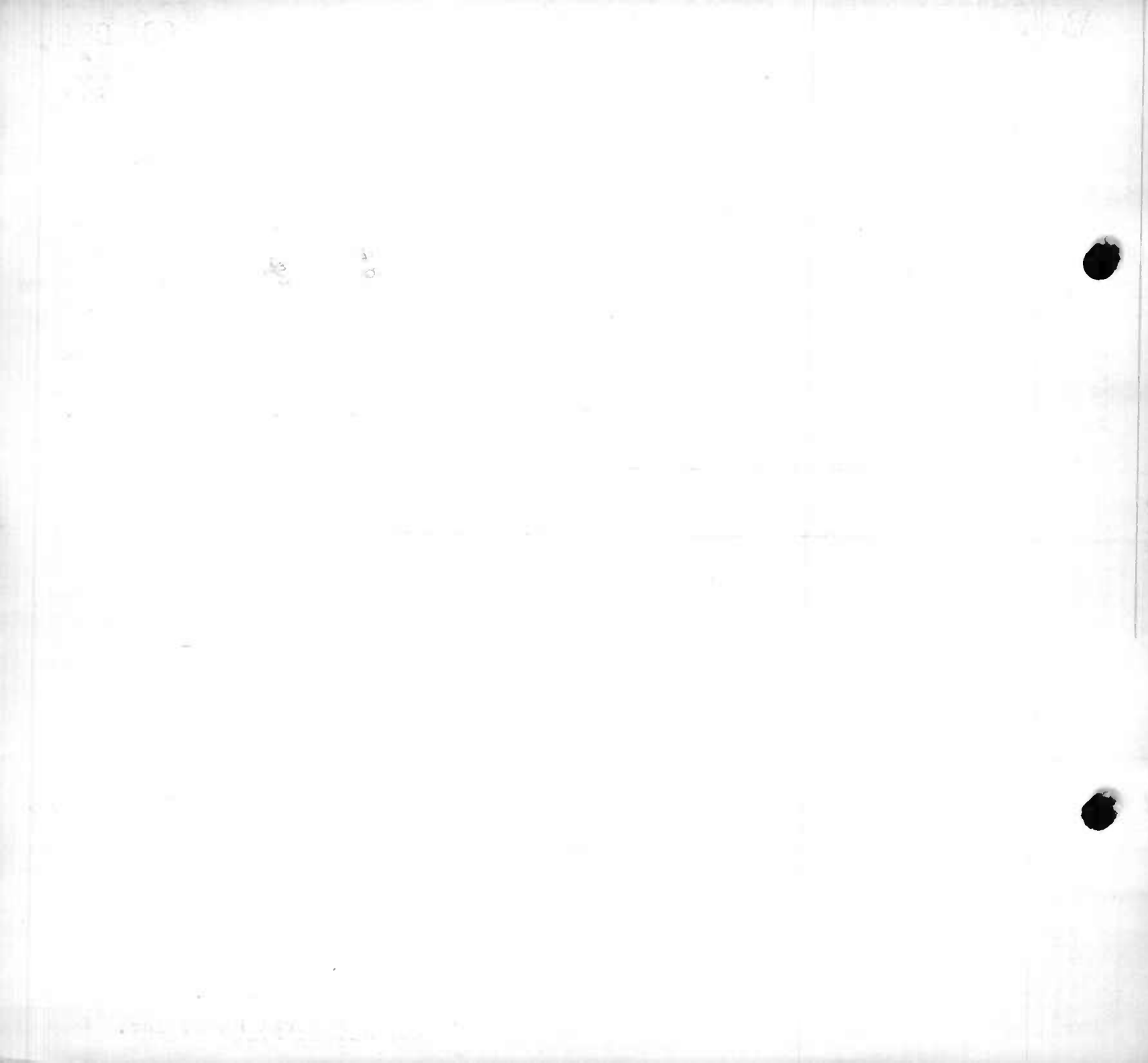
69 0844

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

69 0844

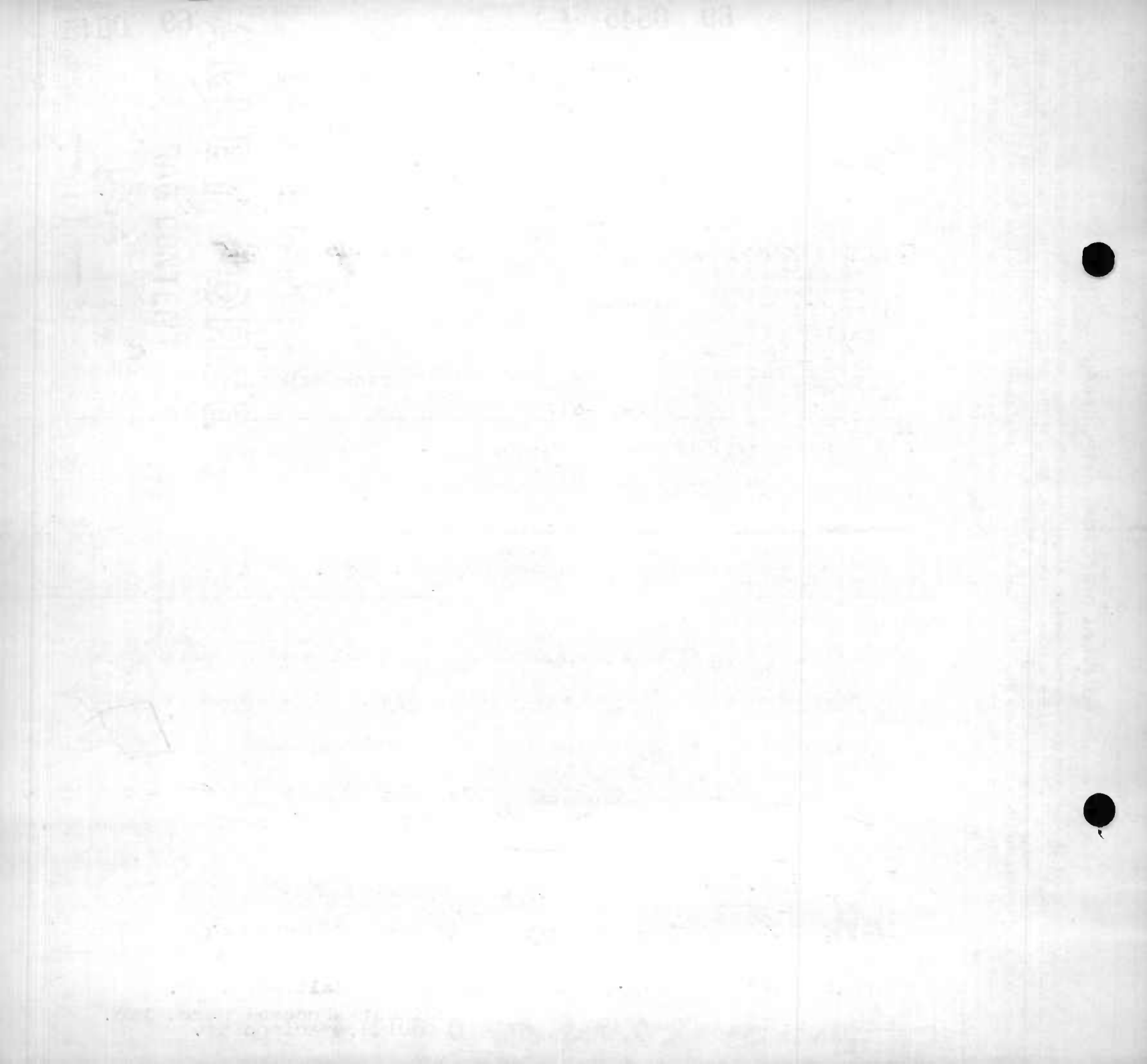
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>PETER E. BIRAC</b>		2. DATE AND HOUR OF DEATH <b>12:30 PM 1/22/69</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>26-07</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>37 Mercy</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired iron operator</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel</b>		8. DATE OF BIRTH <b>9-7-95</b> 9. AGE (in years last birthday) <b>73</b>	
11. BIRTHPLACE (State or foreign country) <b>Austria</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.?</b>		13. FATHER'S NAME <b>Unknown</b>	
14. MOTHER'S MAIDEN NAME <b>Information not available</b>		15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>213-07-7522</b>		16. SOCIAL SECURITY NO. <b>213-07-7522</b>	
17. INFORMANT <b>Rose Anstey, dght. 1290 Walker Ave.</b>		ADDRESS <b>21212</b>		18. <b>431.9 I</b> CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>	
19A. DATE OF OPERATION <b>11/5/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>ICC HEMATOMA</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>JAN 1</b> 19 <b>69</b> to <b>JAN 22</b> 19 <b>69</b> that (1) (we) last saw the deceased alive on <b>JAN 22</b> 19 <b>69</b> and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Frederic H. Sugar</b>				23B. DATE SIGNED <b>1/22/69</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/25/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>	
24D. LOCATION <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1969</b>			
25B. NAME OF REGISTRAR <b>Robert E. [unclear]</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>			
25D. ADDRESS <b>3331 Brehms Lane</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

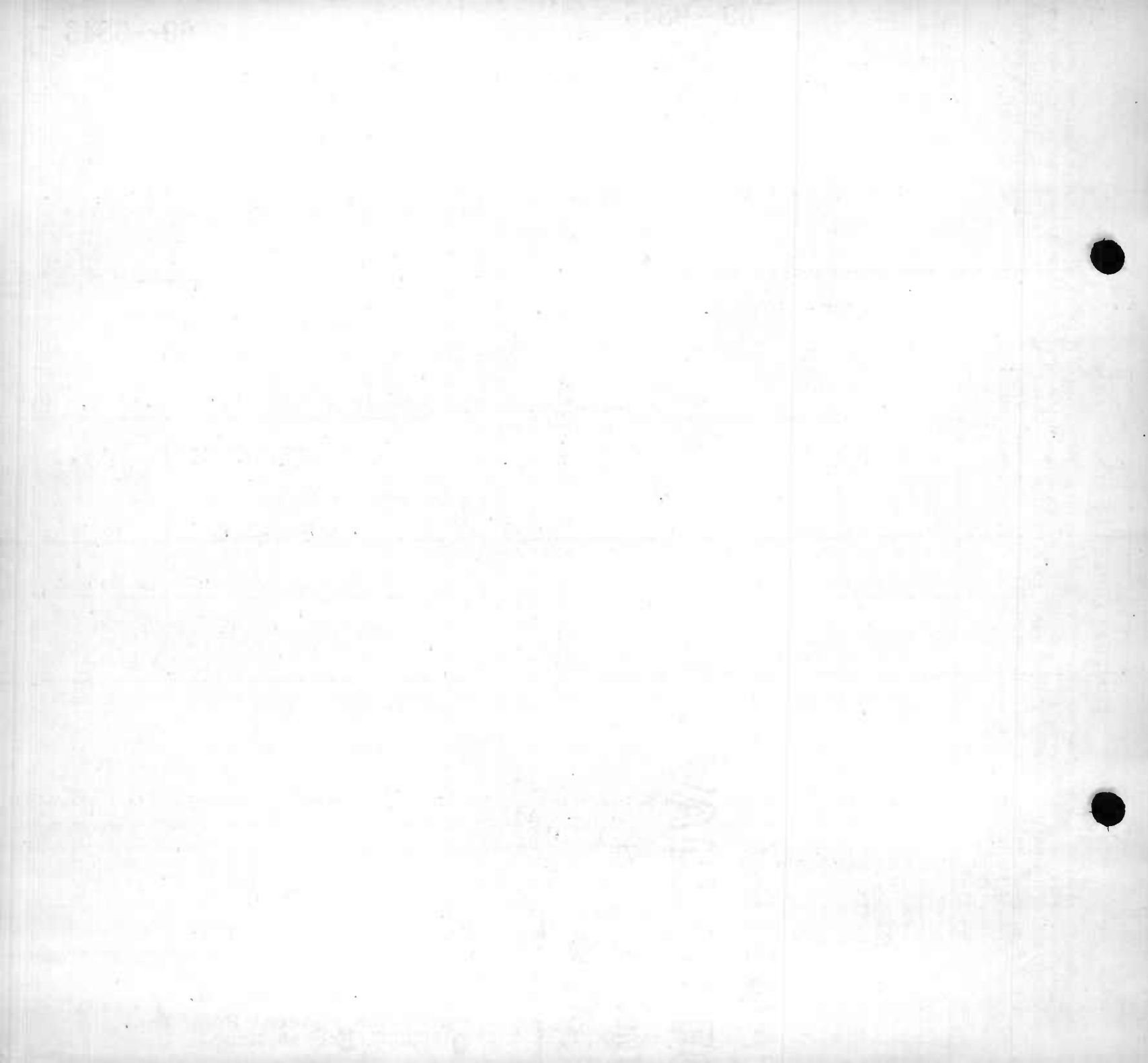
69 0845 BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 0845	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Frances MARY WELKY</b>		2. DATE AND HOUR OF DEATH <b>JAN. 20, 1969 9:30 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>UNION MEMORIAL HOSP.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>7-02</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>44</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>2415 Ashland Ave.</b> <del>XXXXXX XXXX XXXX</del>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-7-84</b>	9. AGE (In years lost birthday) <b>84</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Karl CARL TUREK</b>		14. MOTHER'S MAIDEN NAME <b>BARBARA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-03-6178B</b>		17. INFORMANT <b>Frank Welky SON</b> ADDRESS <b>902 BELNO D AVE. BALTO. MD</b>	
18. <b>486X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Empyema</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pneumonia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>CHRONIC DERILITATION</b>		<b>2 wks.</b>	
(C) <b>2 yrs.</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>JAN 20 19 69</b> to <b>JAN 20 19 69</b> , that (I) <del>was</del> lost saw the deceased alive on <b>JAN 20 19 69</b> and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) (did not) view the body after death.					
23A. SIGNATURE <b>Hong T. Chua</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>Jan 20/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>HONG TI CHUA MD</b>		23D. ADDRESS <b>Union Memorial Hosp.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/23/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1969</b>		25B. NAME OF REGISTRAR <b>John E. Johnson</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>	
25D. ADDRESS <b>2601 E. Madison St.</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">69 0846</span>	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Meredith FRANK M. SMITH</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">1-21-69 2:50 P. M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">34 Bon Secours Hospital.</span>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND.</span> B. COUNTY <span style="font-size: 1.2em;">A.A. Co. 52-00</span>		
			C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER <span style="font-size: 1.2em;">817 OREGON AVE</span> Linthicum, Md. LINT#21090		
5. SEX <span style="font-size: 1.2em;">male</span>	6. RACE <span style="font-size: 1.2em;">white</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">9-4-12</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">56</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Floor Layer - John R. Eareckson Co.</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Pennsylvania</span>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <span style="font-size: 1.2em;">Percy E. Smith</span>			
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Claricy Lowman (Lowman)</span>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span>			
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">213-14-1020</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Anna Lee (nee Crouse) Smith, wife, above</span>			
18. <span style="font-size: 1.2em;">162.1 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH  <span style="font-size: 1.2em;">Bronchogenic carcinoma metastasis</span> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  <span style="font-size: 1.2em;">Bronchogenic carcinoma</span> (B) DUE TO, OR AS A CONSEQUENCE OF: (C).....  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  <span style="font-size: 1.2em;">Days</span>  <span style="font-size: 1.2em;">Months</span>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">1-4-69</span> to <span style="font-size: 1.2em;">1-21-69</span> , that (I) (we) lost saw the deceased alive on <span style="font-size: 1.2em;">1-21-69</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Chaweng Ongkasuwan M.D.</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">1-21-69</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">CHAWENG ONGKASUWAN M.D.</span>				23D. ADDRESS <span style="font-size: 1.2em;">BON SECOURS Hosp.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">1/25/69</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Holy Redeemer Cemetery</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Md.</span>					
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JAN 24 1969</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. [Signature]</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">Schimunek Funeral Home Inc. 3331 Brehms Lane</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0847 CERTIFICATE OF DEATH				REG. NO. 69 0847	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Lina M. Wagner</i>		2. DATE AND HOUR OF DEATH <i>Jan. 14, 1969</i> <i>11:35AM</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>218 Ridgewood Road, Inc.</i> <i>218 Ridgewood Road</i>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>27-14</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>4306 Roland Ave.</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/14/1883</i>	9. AGE (In years last birthday) <i>86</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			13. FATHER'S NAME <i>Carl F. Meislahn</i>		
14. MOTHER'S MAIDEN NAME <i>Bertha Dogge</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <i>No</i>		
16. SOCIAL SECURITY NO. <i>220-44-9393</i>		17. INFORMANT ADDRESS <i>Miss Hildegard Wagner (Same)</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Myocardial infarction</i> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Arteriosclerotic cardiovascular disease</i>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>20 hrs.</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Sev. yrs.</i> (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>10-4</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>10-4</i> 19 <i>64</i> to <i>1-14</i> 19 <i>69</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>1-13</i> 19 <i>69</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <i>Alfred G. Ossman</i> DEGREE				23B. DATE SIGNED <i>1-24-69</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dr. Alfred G. Ossman</i> DEGREE				23D. ADDRESS <i>1101 St. Paul St.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/17/69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Lorraine Park</i>	
24D. LOCATION (City, town, or county) <i>Woodlawn Balto.</i>		24E. STATE <i>Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 24 1969</i>	
25B. NAME OF REGISTRAR <i>Alfred G. Ossman</i>		25C. FUNERAL DIRECTOR ADDRESS <i>H.W. Jenkins &amp; Sons Co. 4905 York Road Balto. 12, Md.</i>			





# FUNERAL DIRECTOR: IMPORTANT

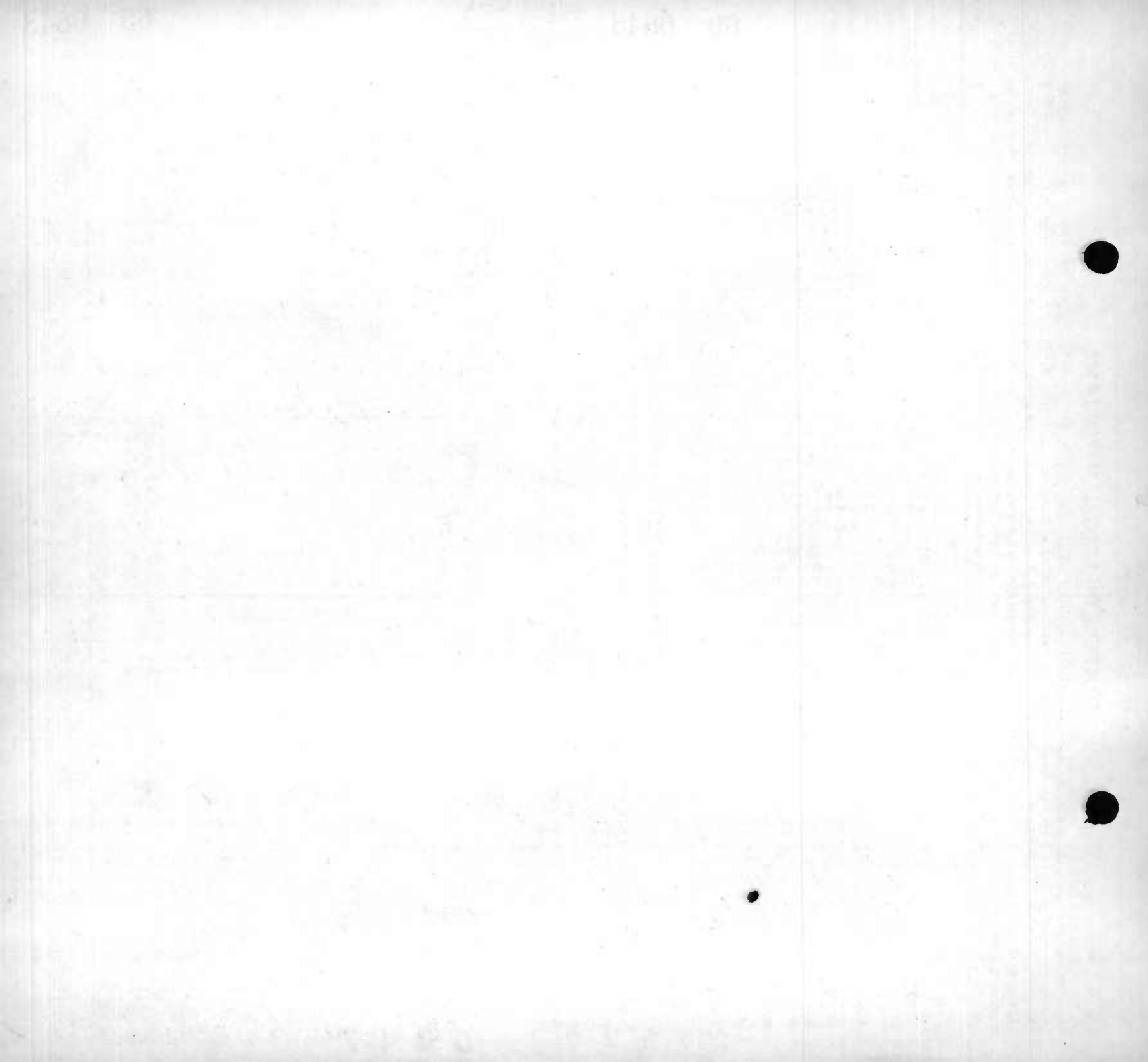
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 69 0848 CERTIFICATE OF DEATH

REG. NO.

69 0848

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Grafton L. Moore</i>		2. DATE AND HOUR OF DEATH <i>Jan 21, 1969 1:15 P. M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>17-03</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>00</i> <i>1110 Myrtle Ave</i>			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>1110 Myrtle Ave</i>		
5. SEX <i>male</i>	6. RACE <i>colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Dec 4, 1890</i>	9. AGE (In years <i>78</i> lost birthday)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laboratory Technician</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Goucher College</i>		11. BIRTHPLACE (State or foreign country) <i>Philadelphia, Pa.</i>	
13. FATHER'S NAME <i>Cyrus W. Moore</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <i>220-12-6129A</i>		17. INFORMANT <i>Jeannetta J. Moore</i>
			ADDRESS <i>Wife, 1110 Myrtle Ave</i>		
18. <i>4-7-91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebro-Vascular Accident</i>  (B) <i>Cerebro-Atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>  <i>?</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0 none</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <i>no</i>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Feb 11 1969</i> to <i>2/21/69</i> 19____, that (I) (we) last saw the deceased alive on <i>Feb 2 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>George M. Donald</i>				23B. DATE SIGNED <i>1/23/69</i>	
23C. PHYSICIAN'S NAME (Type) <i>George M. Donald</i>				23D. ADDRESS <i>844 N Carey Balt. Md</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <i>1-25-69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Int. Auburn</i>	
				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 24 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. [unclear]</i>		25C. FUNERAL DIRECTOR <i>John M. Johnson</i>	
				ADDRESS <i>1700 Duval Hill Ave</i>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>SUSIE Anna TYNES</b>				2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input checked="" type="checkbox"/> <b>January 20, 1969</b> Month Day Year Hour <b>4:00 P.M.</b>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Bon Secour Hospital (DOA)</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 20, 1969</b> <b>5:40 P.M.</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>16-03</b>			
6. SEX <b>female</b>	7. RACE <b>negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>1-24-80</b>		10. AGE (In years last birthday) <b>88</b>		E. STREET AND NUMBER <b>1620 Edmondson Avenue</b>			
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Lenious White</b>			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>Martha</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO. <b>227-72-3068</b>		18. INFORMANT ADDRESS <b>Susie Robinson 1628 Edmondson Ave.</b>			
19. <b>4/12.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <b>No</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB-UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>1/21/69</b>			
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/25/69</b>		24C. NAME of CEMETERY or CREMATORY <b>Windsor</b>		24D. LOCATION (City, town, or county) (State) <b>Southfield, Virginia</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1969</b>		25B. NAME OF REGISTRAR <b>R. S. Fisher</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Charles A. Rice 661 W. Barre St.</b>			

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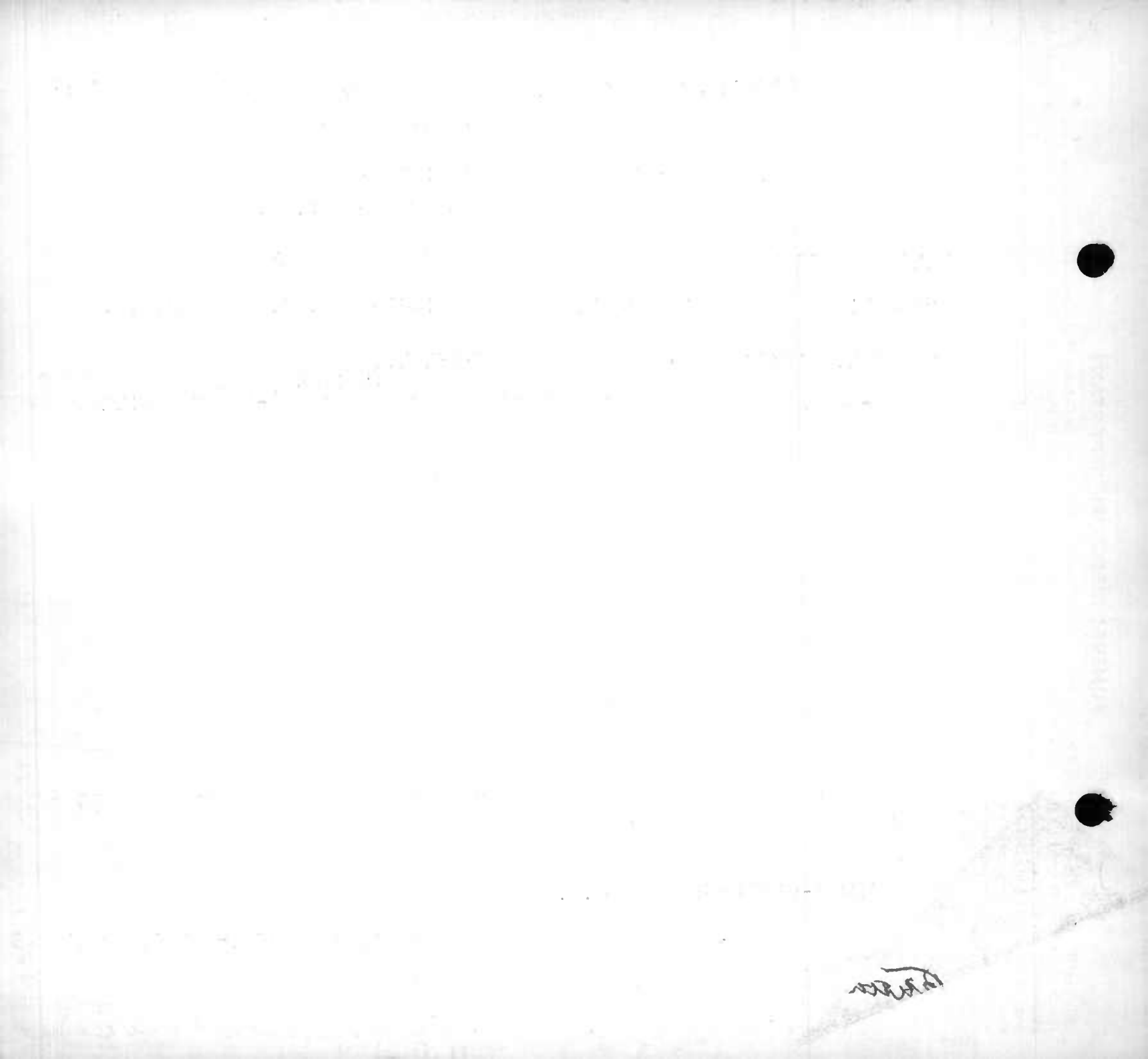
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 0850	
BIRTH NO.		69 0850		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		DICKERSON, HARRY LEE		2. DATE AND HOUR OF DEATH JANUARY 22, 1969 12:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY DISTRICT OF COLUMBIA		V-48	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		C. CITY OR TOWN WASHINGTON		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE		6. RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC		10B. KIND OF BUSINESS OR INDUSTRY AUTOMOBILE		8. DATE OF BIRTH 09 28 24	
13. FATHER'S NAME HARRY L. DICKERSON		14. MOTHER'S MAIDEN NAME ETHEL L. ( )		9. AGE (In years last birthday) 44	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES - KOREAN		16. SOCIAL SECURITY NO. 225 22 4625		11. BIRTHPLACE (State or foreign country) WASHINGTON, D. C.	
				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
				17. INFORMANT BALTIMORE, MD. ADDRESS 21229 ST. AGNES RECORDS-CATON & WILKENS AVES	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF: (B) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: (C)		1-1/2 hr.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JANUARY 7 19 69 to JANUARY 22 19 69 that (IX) (we) last saw the deceased alive on JANUARY 22 19 69 and that (in) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.		23A. SIGNATURE SHAMS-PIRZADEH M.D.		23B. DATE SIGNED 1-22-69	
23C. PHYSICIAN'S NAME (Type) A Shams Pirzadeh		23D. ADDRESS CATON & WILKENS AVES.-BALTO., MD. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1-25-69		24C. NAME of CEMETERY or CREMATORY Harmony Memorial Burial Co.	
24D. LOCATION (City, town, or county) (State) Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 24 1969		25B. NAME OF REGISTRAR Robert E. Jenkins	
25C. FUNERAL DIRECTOR Charles A. Rice		25D. ADDRESS 66 W. Barnes			



# FUNERAL DIRECTOR: IMPORTANT

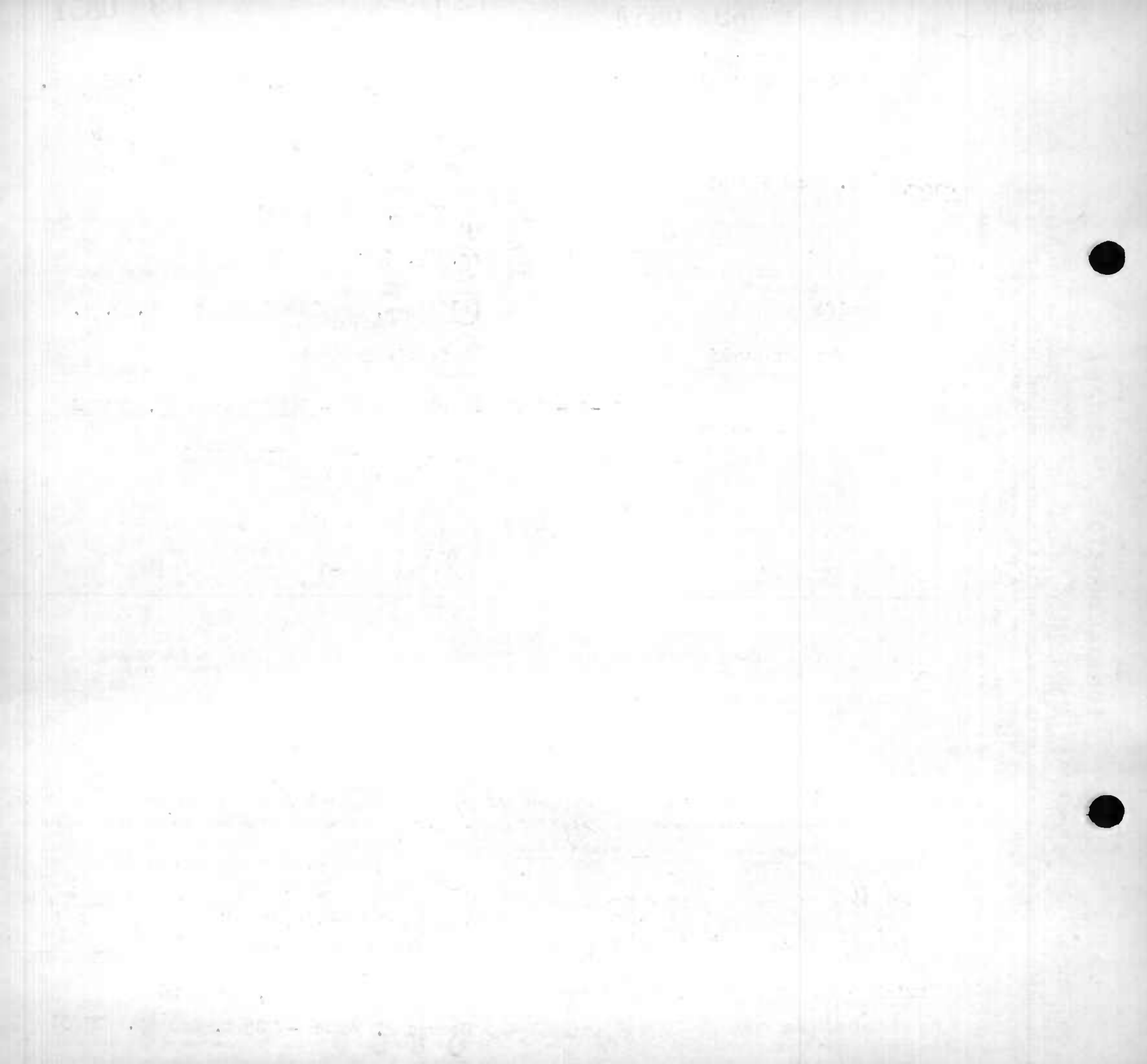
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0851

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 69 0851

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>(Albina) Alvina (Balbina) Mlynski</b>		2. DATE AND HOUR OF DEATH <b>January 22, 1969</b>   <b>4:45</b> p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>526 S. Bond Street</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>526 S. Bond Street</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 29, 1899</b>	9. AGE (In years lost birthday) <b>69</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			13. FATHER'S NAME <b>John Kozlowski</b>		
14. MOTHER'S MAIDEN NAME <b>Sophia Halinska</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>213-16-4187</b>			17. INFORMANT <b>Albert Mlynski - 3927 Hudson St. #21224</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arterio sclerosis + Diabetes</b>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Aug 1967</b> to <b>Sept 1968</b> , that (I) (we) last saw the deceased alive on <b>Sept 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>William A. Tyson</b>				23B. DATE SIGNED <b>1-23-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>William A. Tyson</b>				23D. ADDRESS <b>Bradshaw Rd. Kingville Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/25/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Cross Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Brooklyn, Maryland</b>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Stephens</b>		25C. FUNERAL DIRECTOR <b>George A. Weber - 705 S. Ann St. #21231</b>	
25D. ADDRESS					





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 0852

BIRTH NO.

REG. NO.

1. NAME OF DECEASED  
(Type or Print)

ROOSEVELT BACHUS

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

January 23, 1969

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Lutheran Hospital

(DOA)

3. DATE  
PRONOUNCED DEAD

January 23, 1969

4:40 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

15-47

6. SEX

Male

7. RACE

Negro

B. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

12-25-1912

10. AGE (In years  
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

2304 Poplar Grove Street

11. BIRTHPLACE (State or foreign country)

Greenwood, S.C.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Backus

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Barber

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Ida Backus

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes.

10/21/43 5/15/46

17. SOCIAL  
SECURITY NO.

250-07-7116

18. INFORMANT

ADDRESS

Mrs. Mary Backus 2304 Poplar Grove

19. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

Hypertensive cardiovascular disease

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

January 23, 1969

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1-27-69

24C. NAME of CEMETERY or CREMATORY

Baltimore Nat'l Cem.

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JAN 24 1969

R. B. E. Jackson

MORTON &amp; DYETT F.H. 1701 Laurens St.

WALLLEY POLICE

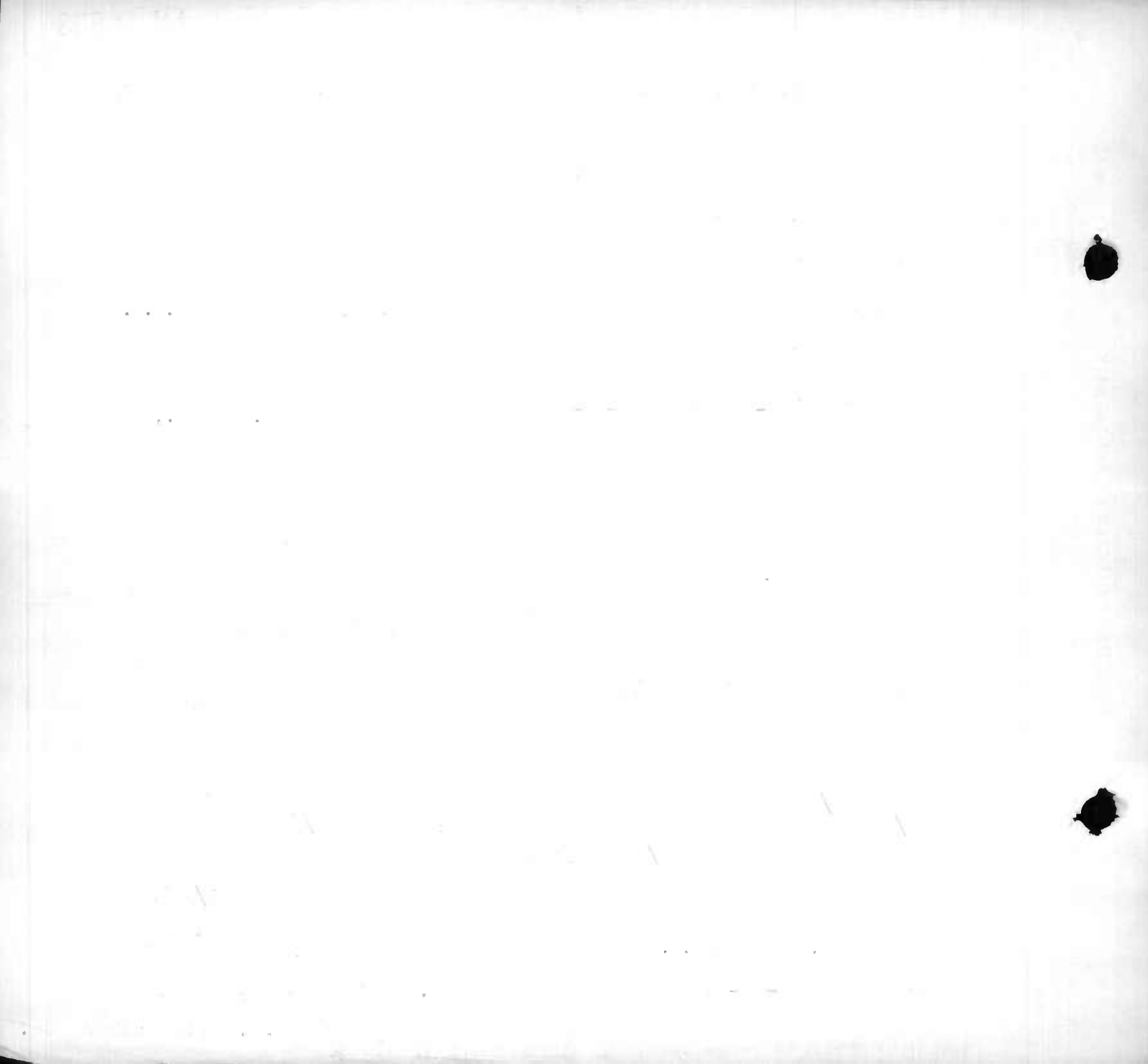
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
69 0853 CERTIFICATE OF DEATH

REG. NO.

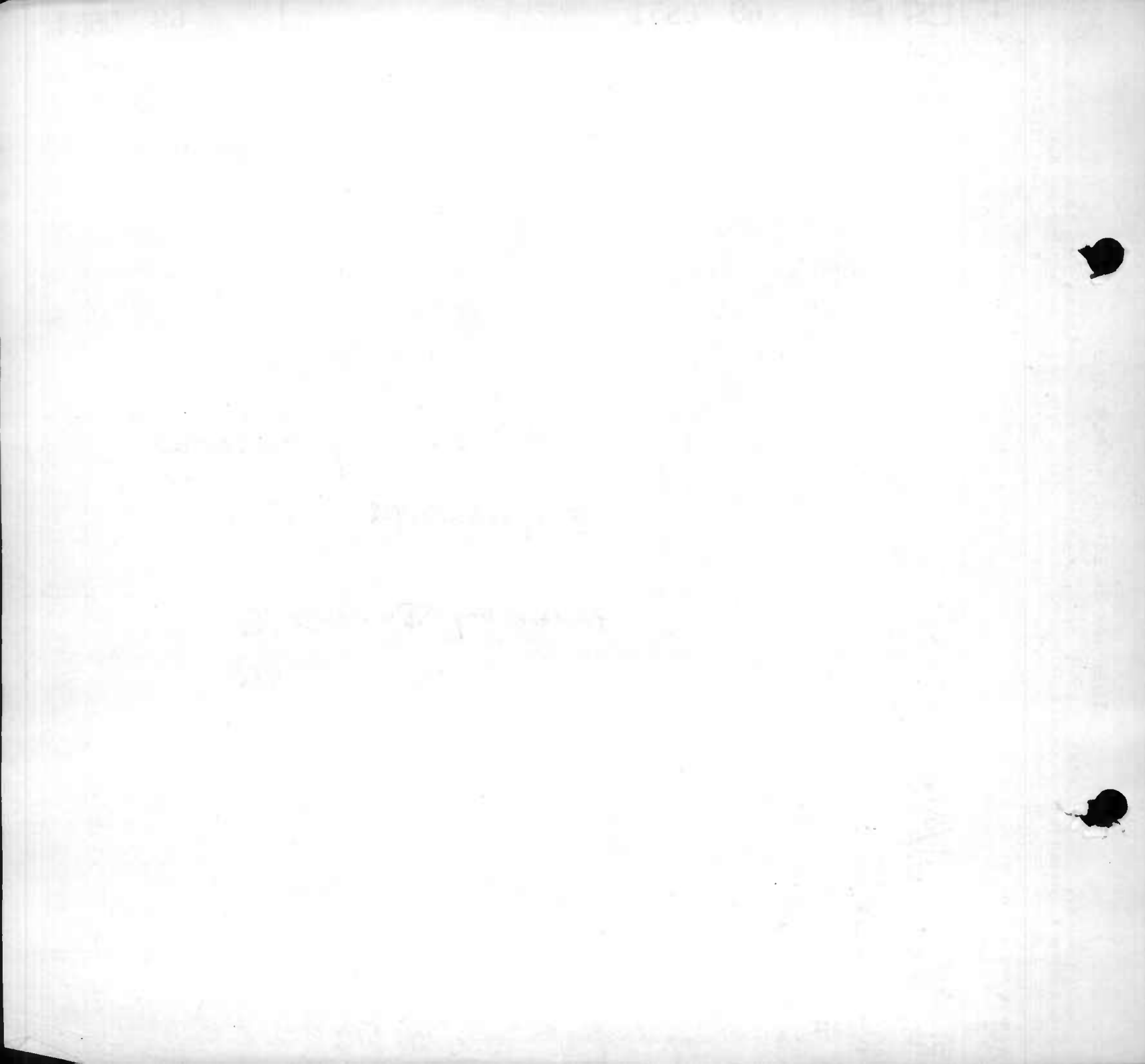
69 0853

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ADDISON, Preston Leroy</b>		2. DATE AND HOUR OF DEATH <b>January 22, 1969 7:50 A</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-09</b>		C. CITY OR TOWN <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>3918 Carlisle Avenue</b>	
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/20/07</b>	9. AGE (In years last birthday) <b>61</b>	If Under 1 Tr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Charles Addison</b>		14. MOTHER'S MAIDEN NAME <b>Emma Addison</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 12/6/40 - 5/29/45</b>		16. SOCIAL SECURITY NO. <b>216-01-6138</b>		17. INFORMANT <b>VA Hospital Records 3900 Loch Raven Blvd., Balto., Md 21218</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>(1) Post op pneumonectomy (2) Arteriosclerotic heart disease</b>		(A) IMMEDIATE CAUSE <b>Cor Pulmonale</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(B) Metastatic Carcinoma of lung</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(C) _____</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 months</b> <b>10 months</b>	
19A. DATE OF OPERATION <b>2, 1965</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Squamous cell carcinoma of lung</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>November 11th 1968</b> to <b>January 22nd 1969</b> that (I) (we) last saw the deceased alive on <b>January 22nd 1969</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>R. A. Twining M.D.</b>		23B. DATE SIGNED <b>1/22/69</b>		23C. PHYSICIAN'S NAME (Type) <b>RALPH H. TWINING, M.D.</b>	
23D. ADDRESS <b>3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>		24. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>1-27-69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore Nat'l Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1969</b>		25B. NAME OF REGISTRAR <b>D. A. F. F. F.</b>		25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>	
25D. ADDRESS <b>1701 Laurens St.</b>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>THERESA GRIFFIN</b>		2. DATE AND HOUR OF DEATH <b>1/22/69</b> <b>16<sup>00</sup></b> <b>A</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>17-03</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Maryland Gen Hosp.</b>				C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>125 GEORGE ST.</b>	
5. SEX <b>F</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>05/15/25</b>	9. AGE (In years last birthday) <b>43</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>FLORIDA</b>	
13. FATHER'S NAME <b>WILLIAM TUTT</b>				14. MOTHER'S MAIDEN NAME <b>GERTRUDE COBB</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO.</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Delores Ricks</b> ADDRESS <b>600 Claymont St.</b>	
18. <b>428XIX 011.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>PULMONARY CONGESTION</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>MYOCARDITIS</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <b>PULMONARY TBC, OLD, @</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A):					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1/17</b> 19 <b>69</b> to <b>time of death</b> 19 <b>69</b> , that (I) (we) lost saw the deceased alive on <b>1/22</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Marcia C. Schmidt MD</b>				23B. DATE SIGNED <b>1/22/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>MARCIA C. SCHMIDT MD</b>				23D. ADDRESS <b>MARYLAND GEN. HOSP., BALTO.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-25-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1969</b>			
25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR <b>WOB-FOR-D-ETT</b> ADDRESS <b>1901 Laurens St</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

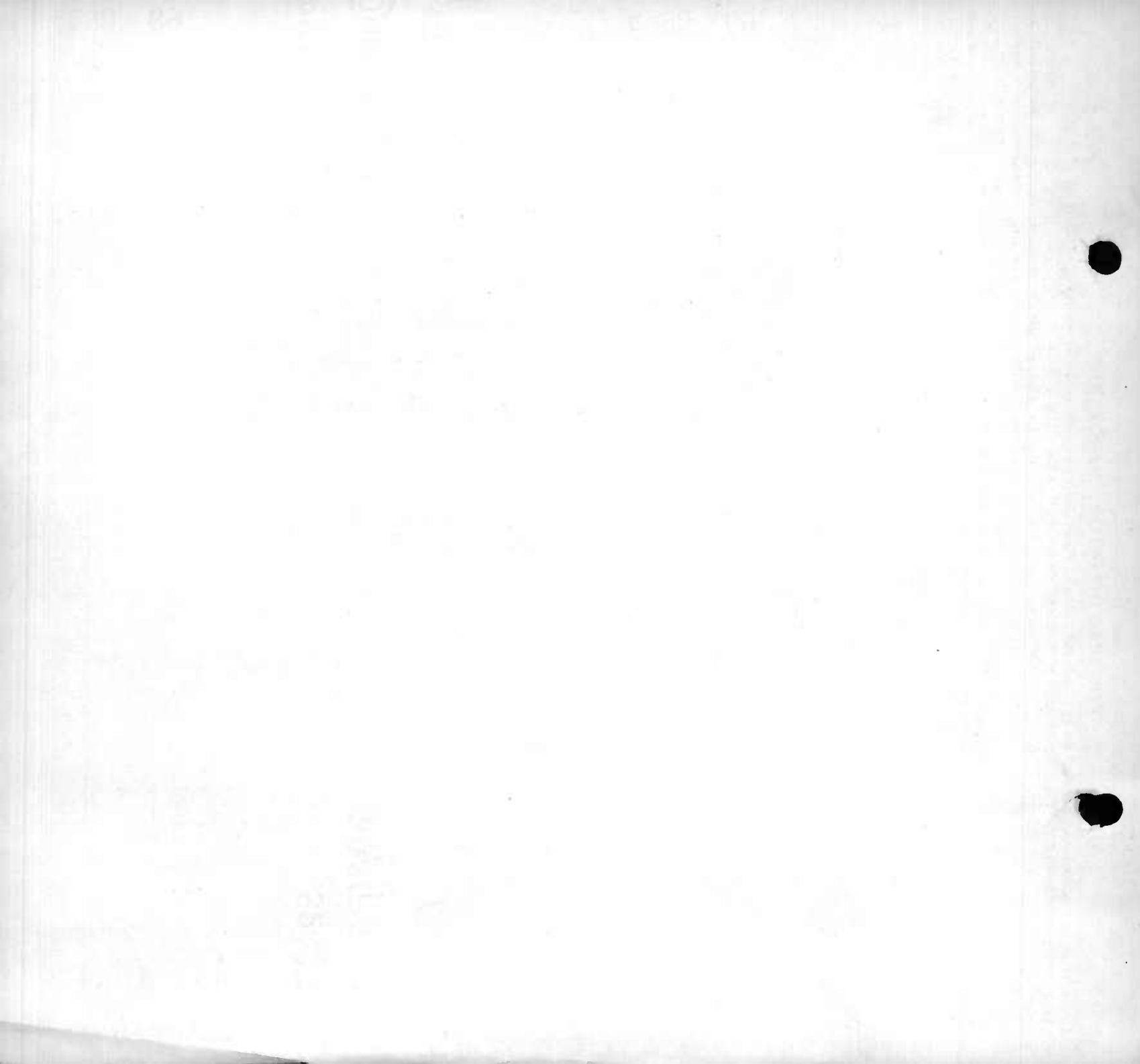
69 0855

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

69 0855

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>WILLIAM W. SMITH</b>		2. DATE AND HOUR OF DEATH <b>Jan. 23, 1969 1:25 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN HOSPITAL OF MARYLAND, INC.</b>				A. STATE <b>MARYLAND</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY <b>16-08</b>	
C. CITY OR TOWN <b>BALTIMORE</b>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>611 N. Augusta Ave # 21229</b>					
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-11-11</b>	9. AGE (In years, last birthday) <b>57</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>FRONT ROYAL VA.</b>	
13. FATHER'S NAME <b>Webster Smith</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Smith</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO.</b>		16. SOCIAL SECURITY NO. <b>219-32-5069</b>		17. INFORMANT <b>Mrs. Shelverd Smith</b>	
				ADDRESS <b>611 N. Augusta Ave</b>	
18. <b>410.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>					
(A) IMMEDIATE CAUSE <b>PULMONARY EDEMA</b> <b>30 MIN.</b> DUE TO, OR AS A CONSEQUENCE OF:					
(B) <b>MYOCARDIAL INFARCTION</b> <b>40 MIN.</b> DUE TO, OR AS A CONSEQUENCE OF:					
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>HYPERTENSION</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>-</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan. 23, 1969</b> to <b>Jan. 23, 1969</b> , that (I) (we) lost saw the deceased alive on <b>Jan. 23, 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Cesar R. Estoye, M.D.</b>				23B. DATE SIGNED <b>Jan. 23, 1969</b>	
23C. PHYSICIAN'S NAME (Type) <b>CESAR R. ESTOYE, M.D.</b>				23D. ADDRESS <b>LUTHERAN HOSPITAL OF MARYLAND</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-27-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Arbutus, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. ...</b>		25C. FUNERAL DIRECTOR <b>Morton S. Jett &amp; Co.</b>	
				ADDRESS <b>1701 Laurens St.</b>	

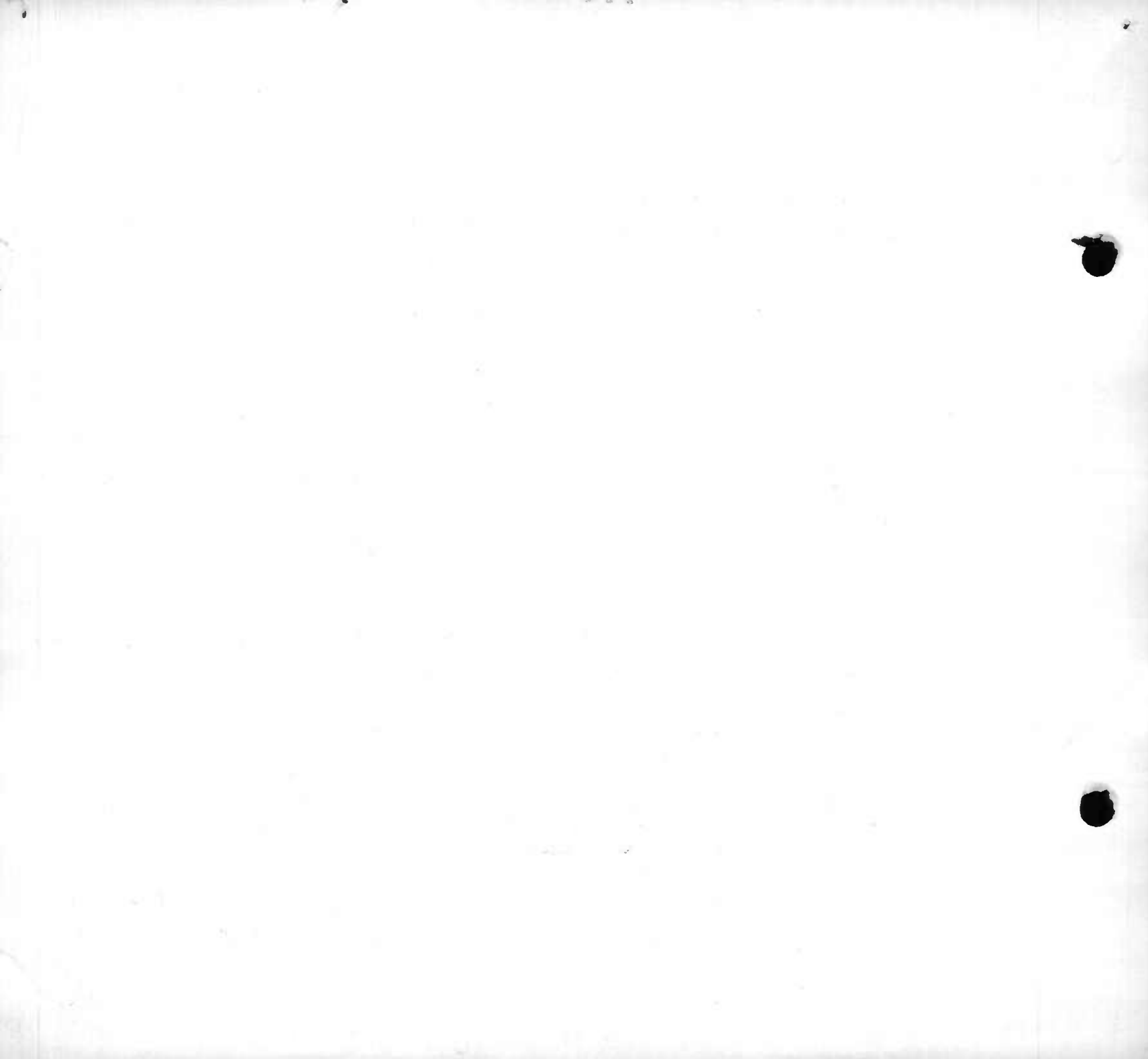




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">69 0856</span>	
<div style="display: flex; justify-content: space-between;"> <span>69 0856</span> <span style="font-size: 1.5em;">69 0856</span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Sadie Brevard</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">January 20, 1969 2<sup>00</sup> P.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE [Where deceased lived, if institution; residence before admission] A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">Baltimore</span>		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">Sinai Hospital of Baltimore</span>			C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <span style="font-size: 1.2em;">317 E. Lafayette Avenue</span>		
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">N</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">11/3/03</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">65</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Domestic Work</span>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">South Carolina</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>
13. FATHER'S NAME <span style="font-size: 1.2em;">Charlie Holiday</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Ella Gillard</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No.</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">250-18-0856</span>	17. INFORMANT <span style="font-size: 1.2em;">Mr. Joseph M. Brevard</span>		ADDRESS <span style="font-size: 1.2em;">Same</span>
18. <span style="font-size: 1.5em;">I</span> <span style="font-size: 1.2em;">1970</span> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE <span style="font-size: 1.2em;">metastatic ca of cervix</span> DUE TO, OR AS A CONSEQUENCE OF:		<span style="font-size: 1.2em;">12 years</span>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <span style="font-size: 1.2em;">mets to lungs + peritoneum</span> DUE TO, OR AS A CONSEQUENCE OF:		<span style="font-size: 1.2em;">2 months</span>
			(C)		
<span style="font-size: 1.5em;">II</span>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			<span style="font-size: 1.2em;">Urinary Tract Infection</span>		<span style="font-size: 1.2em;">2 weeks</span>
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">Yes</span>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <span style="font-size: 1.2em;">NO</span>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <span style="font-size: 1.2em;">—</span>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <span style="font-size: 1.2em;">—</span>	
22. I certify that <del>the</del> (this hospital) attended the deceased from <span style="font-size: 1.2em;">December 31, 1968</span> to <span style="font-size: 1.2em;">January 20, 1969</span> that (I) <del>was</del> last saw the deceased alive on <span style="font-size: 1.2em;">January 20, 1969</span> and that (in my) <del>four</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) <del>did not</del> view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Barry Green, M.D.</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">1/20/69</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Barry Green, M.D.</span>		23D. ADDRESS <span style="font-size: 1.2em;">Sinai Hospital of Baltimore, Inc.</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>	24B. DATE <span style="font-size: 1.2em;">1-26-69</span>	24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Palmist Cem.</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Summer ton, S.C.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JAN 24 1969</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. [unclear]</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Margaret Dyett F.H.</span>	
ADDRESS <span style="font-size: 1.2em;">1701 Laurens St.</span>					



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69 0857 BALTIMORE CITY HEALTH DEPARTMENT

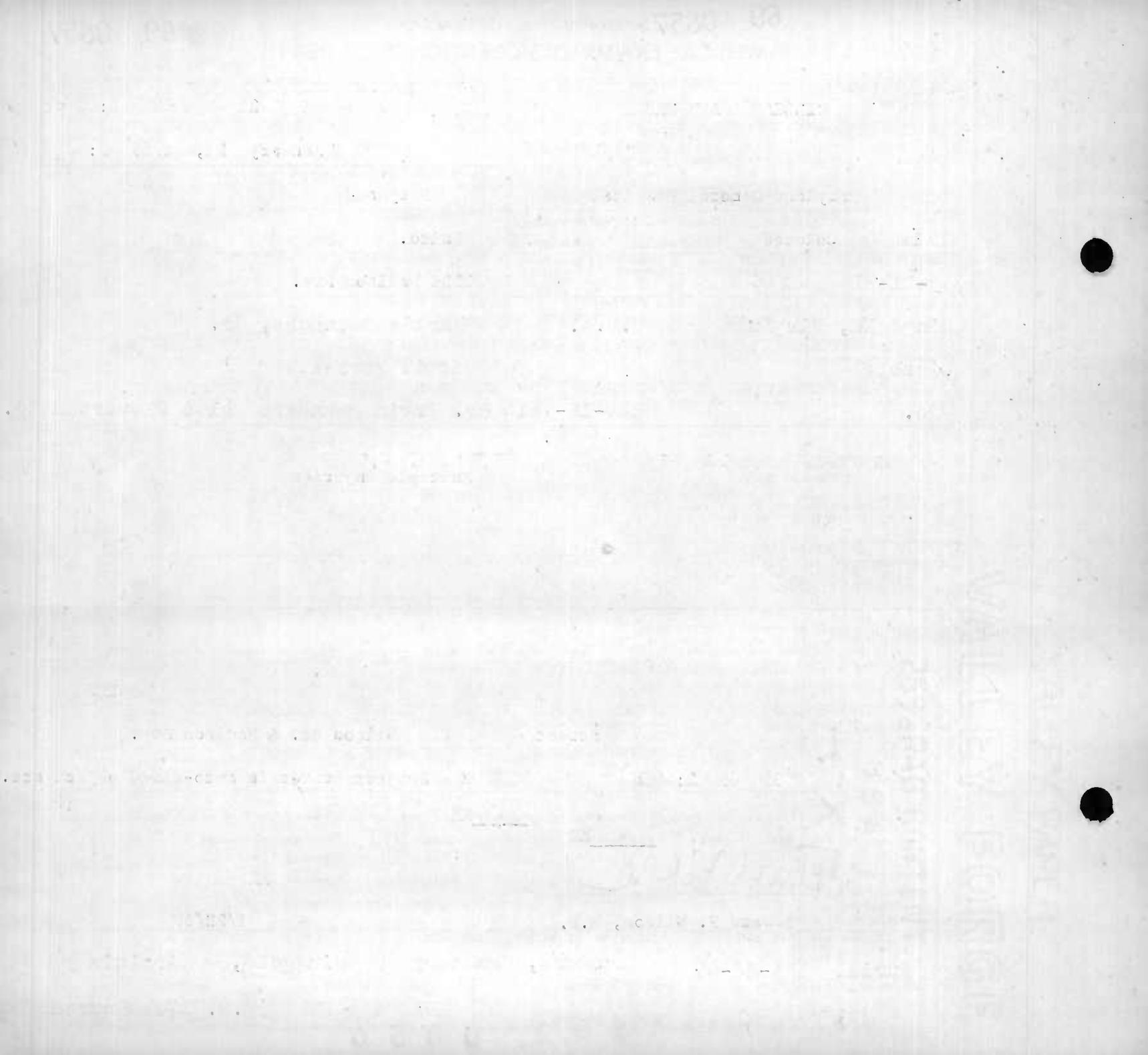
69 0857

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>WILLIAM SAUNDERS</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 1 21 69 9:00 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>48 Maryland General Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 21, 1969 9:00 p.m.</b>	
6. SEX <b>Male</b>		7. RACE <b>Colored</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>13-03</b>	
9. DATE OF BIRTH <b>3-11-22</b>		10. AGE (In years lost birthday) <b>46</b>	
11. BIRTHPLACE (State or foreign country) <b>Ringgold, Virginia</b>		12. CITIZEN OF <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charlie Saunders, Sr.</b>		14. STREET AND NUMBER <b>2228 Madison Ave.</b>	
15. MOTHER'S MAIDEN NAME <b>Hattie Ferrell</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>	
17. SOCIAL SECURITY NO. <b>229-12-1516</b>		18. INFORMANT <b>Mr. Irvin Saunders</b> ADDRESS <b>4106 Flowerton Rd.</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>E81510</b> <b>Multiple injuries</b> <b>Multiple injuries</b> <b>Multiple injuries</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>YES</b>		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Wilson St. &amp; Madison Ave.</b>	
22D. TIME OF INJURY (APPROX.) Month Day Year Hour <b>1 19 69 2:40</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? <b>Subject driver in auto-fixed object acc.</b>		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Edward F. Wilson, M.D.</b> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1/22/69</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-26-69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Saunders, Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Ringgold, Virginia</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1969</b>		25B. NAME OF REGISTRAR <b>MORTON &amp; DYETT F.H.</b>	
25C. FUNERAL DIRECTOR <b>1701 Laurens St</b>		ADDRESS	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>MARY CHERRY</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>1 17 69 12:03 PM</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>00 1329 Shields Place</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 17, 1969 12:03 PM</b>	
6. SEX <b>Female</b>		7. RACE <b>Colored</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>17-03</b>	
9. DATE OF BIRTH <b>3-15-04</b>		10. AGE (In years last birthday) <b>64</b>	
11. BIRTHPLACE (State or foreign country) <b>Rocky Mount, N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Mrs. Bessie Austin</b>		ADDRESS <b>609 W. Lafayette</b>	
19. <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) (Minute)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Edward F. Wilson</b> M.D. EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1/17/69</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-24-69</b>	
24C. NAME of CEMETERY or CREMATORY <b>Mount Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>		ADDRESS <b>1701 Laurens St.</b>	

WATLEY FOLIO

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-350 69 0860		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO. <u>2001010101</u>		REG. NO. <u>69 0860</u>	
1. NAME OF DECEASED (Type or Print) <u>BURLEIGH NAYAN WHITNEY</u>		2. DATE AND HOUR OF DEATH <u>1-23-69</u> <u>8:28 AM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>SOUTH-BALTIMORE-GENERAL-HOSP.</u> <u>43</u>		A. STATE <u>MD</u> B. COUNTY <u>928 S. HANOVER ST.</u> C. CITY OR TOWN <u>BALTIMORE, MD</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>13-01</u>	
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-04</u>
9. AGE (In years last birthday) <u>64</u>		10. UNDER 1 Yr. Months: Days: Hours: Min.	11. UNDER 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. LABORER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>GULF OIL CORP.</u>	
11. BIRTHPLACE (State or foreign country) <u>NORTH-CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>MAC K WHITNEY</u>		14. MOTHER'S MAIDEN NAME <u>LUDDIE BURNET</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>815-09-1603</u>	
17. INFORMANT <u>BENEDICT WHITNEY</u>		ADDRESS <u>928 S. HANOVER ST</u>	
18. <u>410.9 I</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral Artery</u>	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Probable Myocardial Infarction</u>	
ANTECEDENT CAUSES		(C) <u>Arteriosclerosis</u>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<u>2 HF</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>/</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>/</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/27 1968</u> to <u>12/26 1968</u> that (I) (we) last saw the deceased alive on <u>12/26 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>R. F. H. B. W.</u>		23B. DATE SIGNED <u>1-23-69</u>	
23C. PHYSICIAN'S NAME (Type) <u>R. F. H. B. W.</u>		23D. ADDRESS <u>886 H</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>	24B. DATE <u>1/28/69</u>	24C. NAME OF CEMETERY OR CREMATORY <u>WINDY HILL CEMETERY</u>	24D. LOCATION (City, town, or county) (State) <u>ELIZABETH CITY N.C.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 24 1969</u>	25B. NAME OF REGISTRAR <u>R. F. H. B. W.</u>	25C. FUNERAL DIRECTOR <u>W. H. B. W.</u> ADDRESS <u>638 N. GUM ST</u>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

69 0859

BIRTH NO.		69 0859	
1. NAME OF DECEASED (Type or Print) <b>Scruggs Charles A.</b>		2. DATE AND HOUR OF DEATH <b>Jan. 20, 1969 3:40 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>South Baltimore General Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>25-62</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>South Baltimore General Hospital</b>		C. CITY OR TOWN <b>BALTIMORE, MD</b>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>M</b>		6. RACE <b>Negro</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/23/46</b>	
9. AGE (In years last birthday) <b>23</b>		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None - mentally retarded</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Scruggs, James -</b>		14. MOTHER'S MAIDEN NAME <b>BANKS, Carrie Md.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-0-</b>	
17. INFORMANT <b>Chart</b>		ADDRESS	
18. <b>34591</b>		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral edema</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cardiac arrest</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiac arrest</b>	
		(B) <b>Cardiopulmonary resuscitation - failed</b> DUE TO, OR AS A CONSEQUENCE OF: <b>3 days</b>	
		(C) <b>Chronic seizure disorder</b> DUE TO, OR AS A CONSEQUENCE OF: <b>23 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (if this hospital) attended the deceased from <b>1/16</b> 19 <b>69</b> to <b>1/20</b> 19 <b>69</b> that (i) (we) last saw the deceased alive on <b>1/20</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>S.R. Calvert M.D.</b>		23B. DATE SIGNED <b>1/20/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>S.R. Calvert</b>		23D. ADDRESS <b>Morton &amp; Dyett F.H. 1701 Laurens St.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-23-69</b>	
24C. NAME of CEMETERY or CREMATORY <b>Arbutus Mem. Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Tabor</b>	
25C. FUNERAL DIRECTOR <b>Morton &amp; Dyett F.H.</b>		ADDRESS <b>1701 Laurens St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0861		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 69 0861	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>LESTER L. BANKS</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH <u>1-22-69 6:15 P. M.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>37 MERCY HOSPITAL</u>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN <u>BALTIMORE</u>	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER <u>7113 YORK RD. 21212</u>	
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-10-99</u>	9. AGE (In years last birthday) <u>69</u>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <u>GRANVILLE BANKS</u>		14. MOTHER'S MAIDEN NAME <u>MARY WHITE</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-10-8332</u>		17. INFORMANT ADDRESS <u>J. Robert Banks-567 Gen Muhlenberg Road</u>			
18. <u>410.9 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>EXTENSIVE King of Prussia MYOCARDIAL INFARCTION</u> 1 (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, If any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>HEMORRHAGE FROM ATHEROSCLEROTIC PLAQUE OF CORONARY ARTERY</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>1</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <u>YES</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 1/2 hours</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (1 Month) (1 Day) (1 Year) (1 Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>1-22-1969</u> to <u>1-22-1969</u> that (1) (we) last saw the deceased alive on <u>1-22-1969</u> and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u> M.D.				23B. DATE SIGNED <u>1-23-69</u>		23C. PHYSICIAN'S NAME (Type) <u>BAYANI L. MANALO, M.D.</u>	
23D. ADDRESS <u>MERCY HOSPITAL</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-25-69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Woodlawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Marion Armacost -4600 Liberty Hghts. Ave.</u>			

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FOR APPROVAL

## FUNERAL DIRECTOR: IMPORTANT

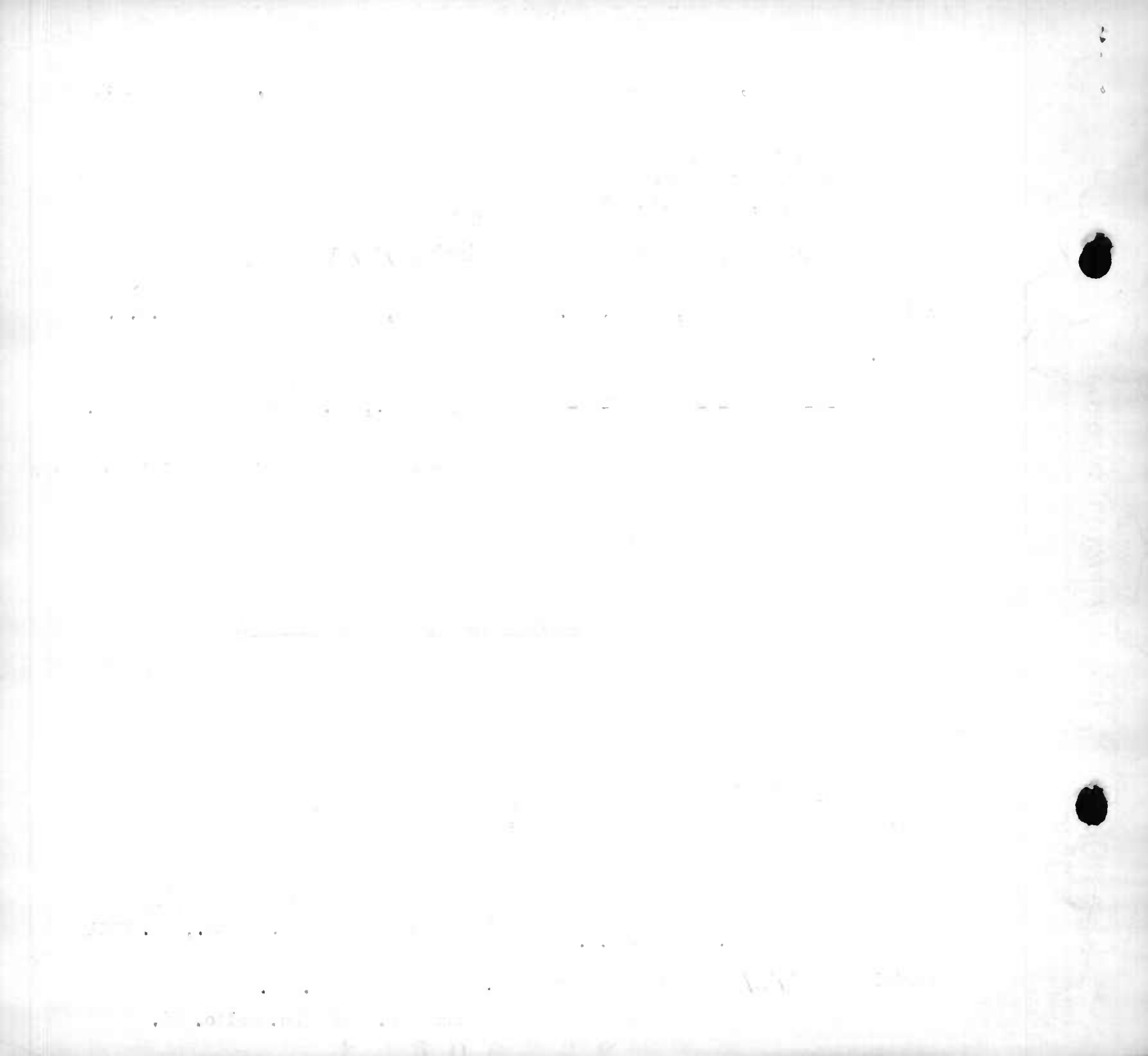
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
69 0862 CERTIFICATE OF DEATH

REG. NO.

69 0862

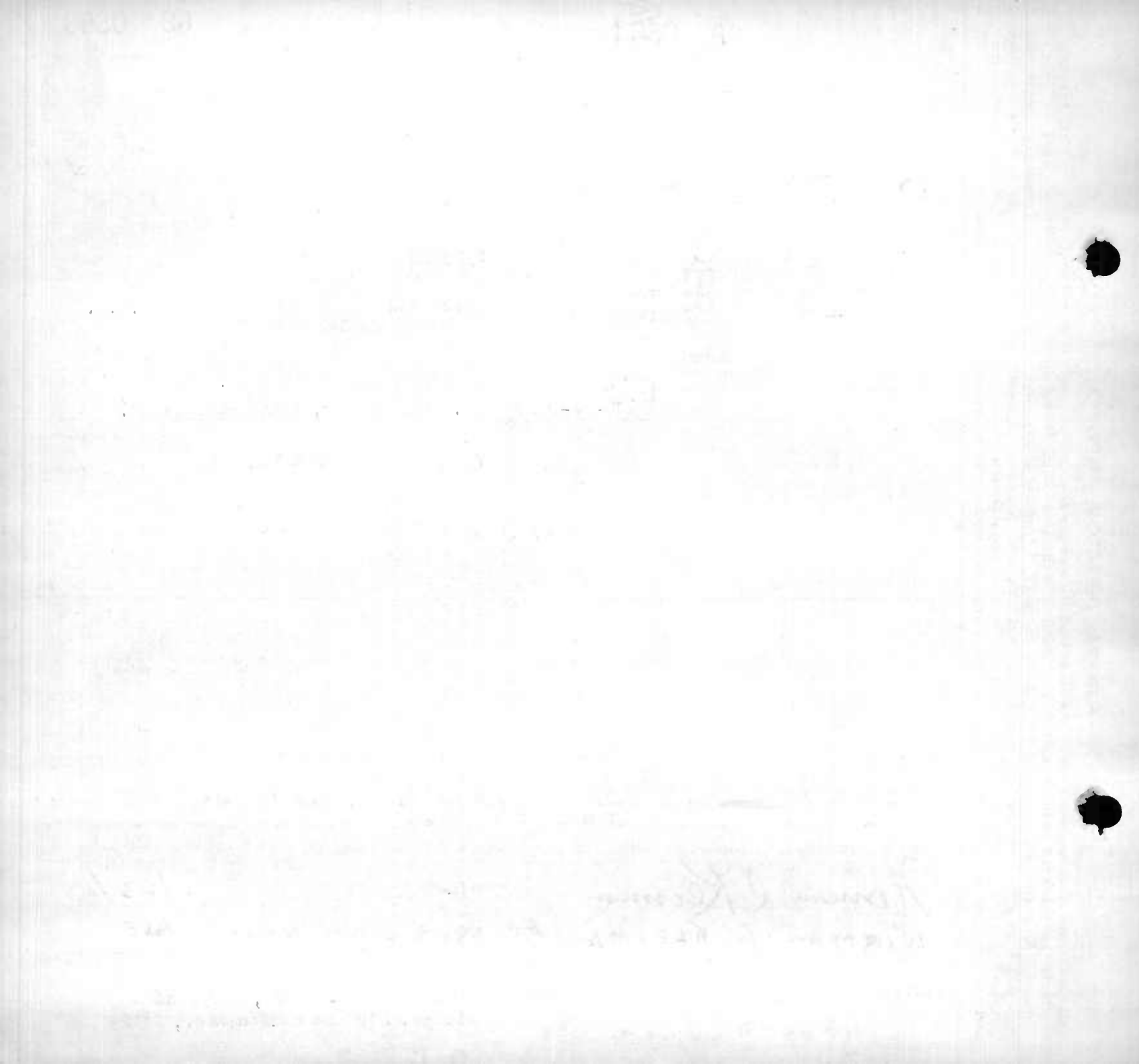
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		CARBERRY, ETHEL GIBSON		JANUARY 14, 1969 10:20 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 23 VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BLVD BALTIMORE, MARYLAND 21218		A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 8203 LOCH RAVEN BLVD			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/29/01 6/30/01 67	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) telephone Operator		10B. KIND OF BUSINESS OR INDUSTRY VAH, BALTO. MD.		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN W. GIBSON			
14. MOTHER'S MAIDEN NAME MARY DOYLE		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 1-5-43 TO 5-4-43			
16. SOCIAL SECURITY NO. 215-18-6349		17. INFORMANT Records VAH, BALTO., MD. 3900 LOCH RAVEN BLVD.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Pneumococcal Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 to 4 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Possible overdose of tranquilizer					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from JANUARY 14, 1969 to JANUARY 14, 1969 that (X) (we) last saw the deceased alive on JANUARY 14, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David N. Marine		23B. DATE SIGNED 1/15/69		23C. PHYSICIAN'S NAME (Typo) DAVID N. MARINE, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/17/69		24C. NAME of CEMETERY or CREMATORY New Cathedral Cem.	
24D. LOCATION Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 24 1969			
25B. NAME OF REGISTRAR Robert E. Fairbanks		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 0863
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Catherine Dodson		1/23/69 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  00 <del>XXXXXXXXXXXX</del> 1514 Oakridge Road			A. STATE Maryland		
			B. COUNTY Baltimore Co. 53-00		
			C. CITY OR TOWN Arbutus		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER 929 Circle Drive, 21227		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/25/08	9. AGE (In years last birthday) 60	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10B. KIND OF BUSINESS OR INDUSTRY Christensen Anderson		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Norris		
14. MOTHER'S MAIDEN NAME			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 219-07-5576			17. INFORMANT Mr. John Dodson, 1514 Oakridge Rd.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  CARCINOMATOSIS  (B) CARCINOMA - LUNG. DUE TO, OR AS A CONSEQUENCE OF:  (C).....		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months 1 yrs					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this physician) attended the deceased from JAN 6 1968 to JAN 23 1969, that (I) (we) last saw the deceased alive on JAN 22 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Norman R. Kleiman				23B. DATE SIGNED 1/23/69	
23C. PHYSICIAN'S NAME (Type) NORMAN R. KLEIMAN MD				23D. ADDRESS 3803 EDMONDSON AVE.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1/25/69		Lorraine Park Cemetery	
24D. LOCATION (City, town, or county)		24E. (State)			
Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1969		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., 21229	





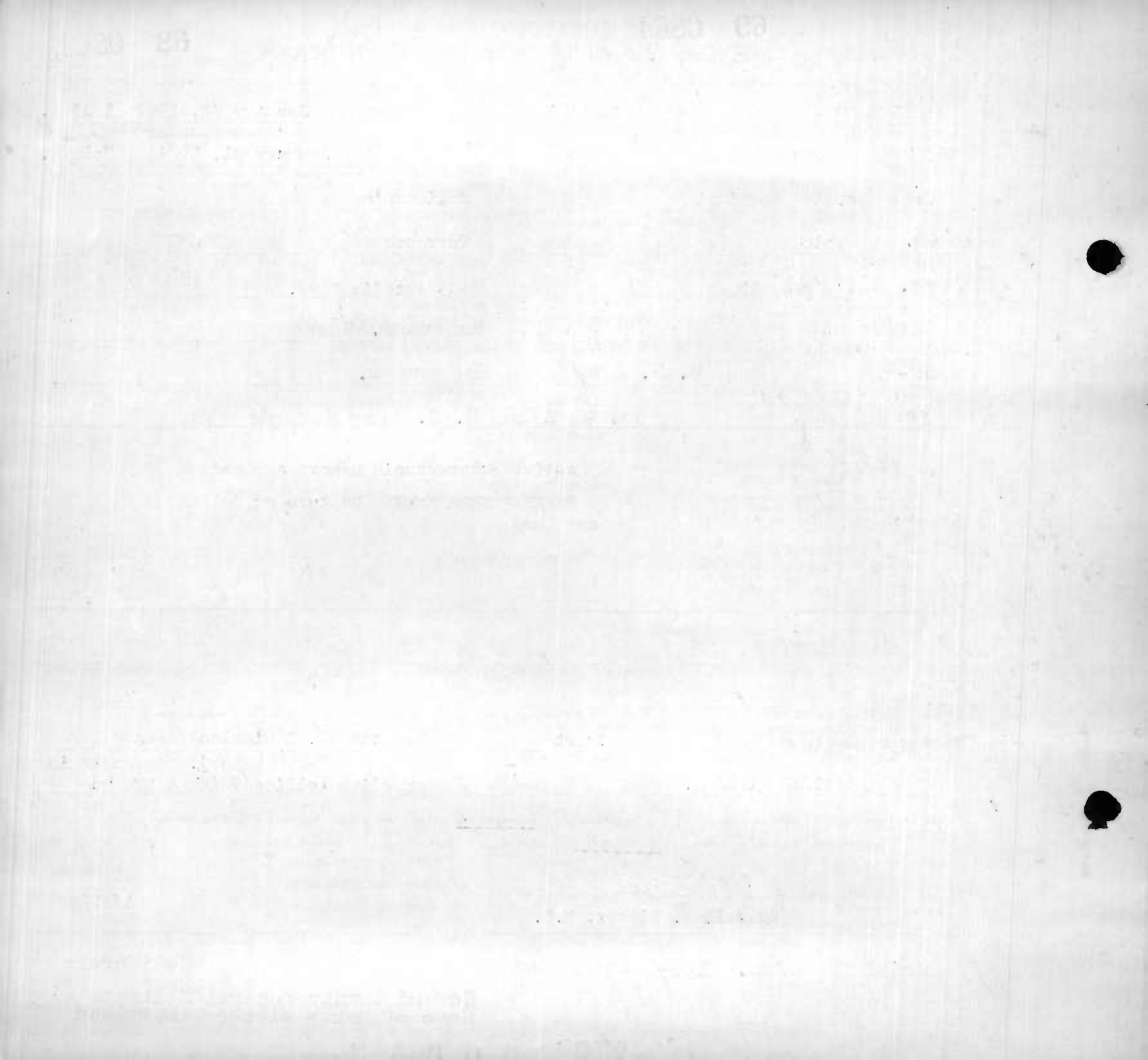
69 0864 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 0864

BIRTH NO.

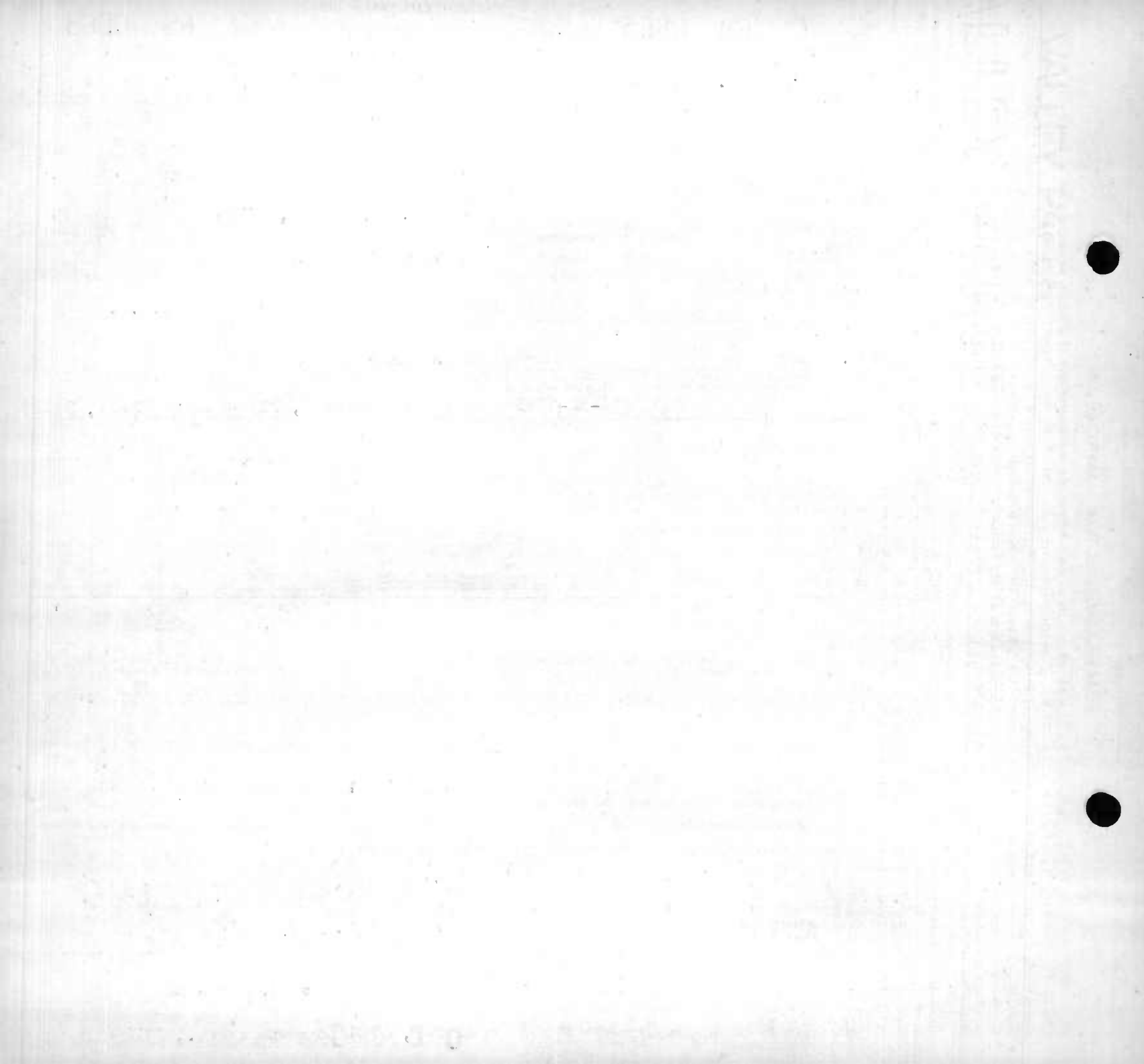
1. NAME OF DECEASED (Type or Print) <b>RICHARD SCHOUBE</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>January 21, 1969</b> 1:35 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 21, 1969</b> 2:16 A.M.	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>California</b> B. COUNTY <b>V-04</b>	
6. SEX <b>male</b>	7. RACE <b>white</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <b>Torrence</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
9. DATE OF BIRTH <b>Dec. 21, 1941</b> 27		E. STREET AND NUMBER <b>3435 Artesia Blvd.</b>	
11. BIRTHPLACE (State or foreign country) <b>California</b>		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SP-5</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>U. S. Army</b>	
15. MOTHER'S MAIDEN NAME <b>Imogene L.</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes</b>	
17. SOCIAL SECURITY NO. <b>553 60 1710</b>		18. INFORMANT ADDRESS <b>U. S. Army Records</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Massive Subarachnoid Hemorrhage and Rupture of Spleen and Lung</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Massive Subarachnoid Hemorrhage and Rupture of Spleen and Lung</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Fayette ST. &amp; Highland Avenue</b>		22D. TIME OF INJURY (APPROX.) <b>1/21/69 1:30 A. M.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>subj. passenger in car which collided with a BTC bus</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) DATE SIGNED <b>1/21/69</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Jan. 1969</b>	24C. NAME of CEMETERY or CREMATORY <b>Inglewood</b>	24D. LOCATION (City, town, or county) (State) <b>California</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1969</b>	25B. NAME OF REGISTRAR <b>R. S. Fisher</b>	25C. FUNERAL DIRECTOR <b>Howard County Funeral Home of Harry Witzke</b>	ADDRESS <b>Ellicott City Maryland</b>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>69 0865</b>
<div style="font-size: 2em; font-weight: bold;">m-325</div> <div style="font-size: 2em; font-weight: bold;">69 0865</div>		CERTIFICATE OF DEATH		
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH
		Harriet C. Mattson		1/22/69 <span style="float: right;">P.M.</span>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  <b>00</b>		A. STATE <b>MD</b>		
		B. COUNTY <b>28-34</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?
703 Hunting Place		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER		
		703 Hunting Place, 21229		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
female	white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	6/27/04	64
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Housewife				New York
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
Joseph C. Maloy		Anna Toner		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT
no		218-52-1883		Miss Mary Mattson, 703 Hunting Place, 21229
18. <b>342.0 I</b>		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				
ANTECEDENT CAUSES		(B) <i>unknown</i> DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
II		(C) <i>hypert. C.V. disease decompensation</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0	✓	✓		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
✓	✓	✓		
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?		
(Month) (Day) (Year) (Hour)	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 15</i> 19 <i>69</i> to <i>Jan</i> 19 <i>69</i> and that (I) (we) last saw the deceased alive on <i>Jan 15</i> 19 <i>69</i> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE		23B. DATE SIGNED		
<i>Kurt Levy</i>		<i>1/23/69</i>		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
KURT LEVY MD		3105 N. Charles Street		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)	
Burial	1/25/69	Woodlawn Cemetery	Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		
JAN 24 1969	<i>Robert E. Stankovic</i>	Witzke, 4101 Edmondson Ave., 21229		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## 69 0866 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 69 0866

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>McKinney, James</u>		2. DATE AND HOUR OF DEATH <u>January 19, 1969 2:00 P. M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u> <u>Baltimore, Maryland</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>Maryland</u> , B. COUNTY <u>Baltimore City</u>	
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>420 S. Carey St.</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/11/34</u>	9. AGE (In years, months, days) <u>34</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lab. Tech.</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
13. FATHER'S NAME <u>Walter McKinney</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Lampkins</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>237-446111</u>		17. INFORMANT <u>Jennie Lampkins</u> ADDRESS <u>Gastonia N.C.</u>	
18. <u>01/19/69</u> I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Meningitis, possibly Tuberculosis</u>		<u>7 days</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Possible pulmonary Tbc.?</u>			
		(C) <u>Bronchopneumonia</u>		<u>7 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>Bronchopneumonia</u>		<u>7 days</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>this hospital</u> attended the deceased from <u>1/19/69</u> 19 <u>69</u> to <u>1/19/69</u> 19 <u>69</u> that (I) <u>we</u> last saw the deceased alive on <u>1/19</u> 19 <u>69</u> and that (in my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) (did not) view the body after death.					
23A. SIGNATURE <u>Stuart V. Grandis</u>		23B. PHYSICIAN'S NAME (Type) <u>Stuart V. Grandis</u>		23C. DATE SIGNED <u>1/19/69</u>	
23D. ADDRESS <u>University Hospital</u>		23E. PHYSICIAN'S DEGREE <u>M.D.</u>		23F. ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Shipped</u>		24B. DATE <u>1/24/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Harmony Cem.</u>	
24D. LOCATION <u>Gastonia N.C.</u>		24E. CITY, TOWN, OR COUNTY		24F. STATE	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 24 1969</u>		25B. NAME OF REGISTRAR <u>R. B. E. Stasko</u>		25C. FUNERAL DIRECTOR <u>W. B. B. General</u>	
25D. ADDRESS <u>3189 Johnson St.</u>					

Veritas 4/1/1960

*[Faint handwritten notes, possibly bleed-through from the reverse side.]*

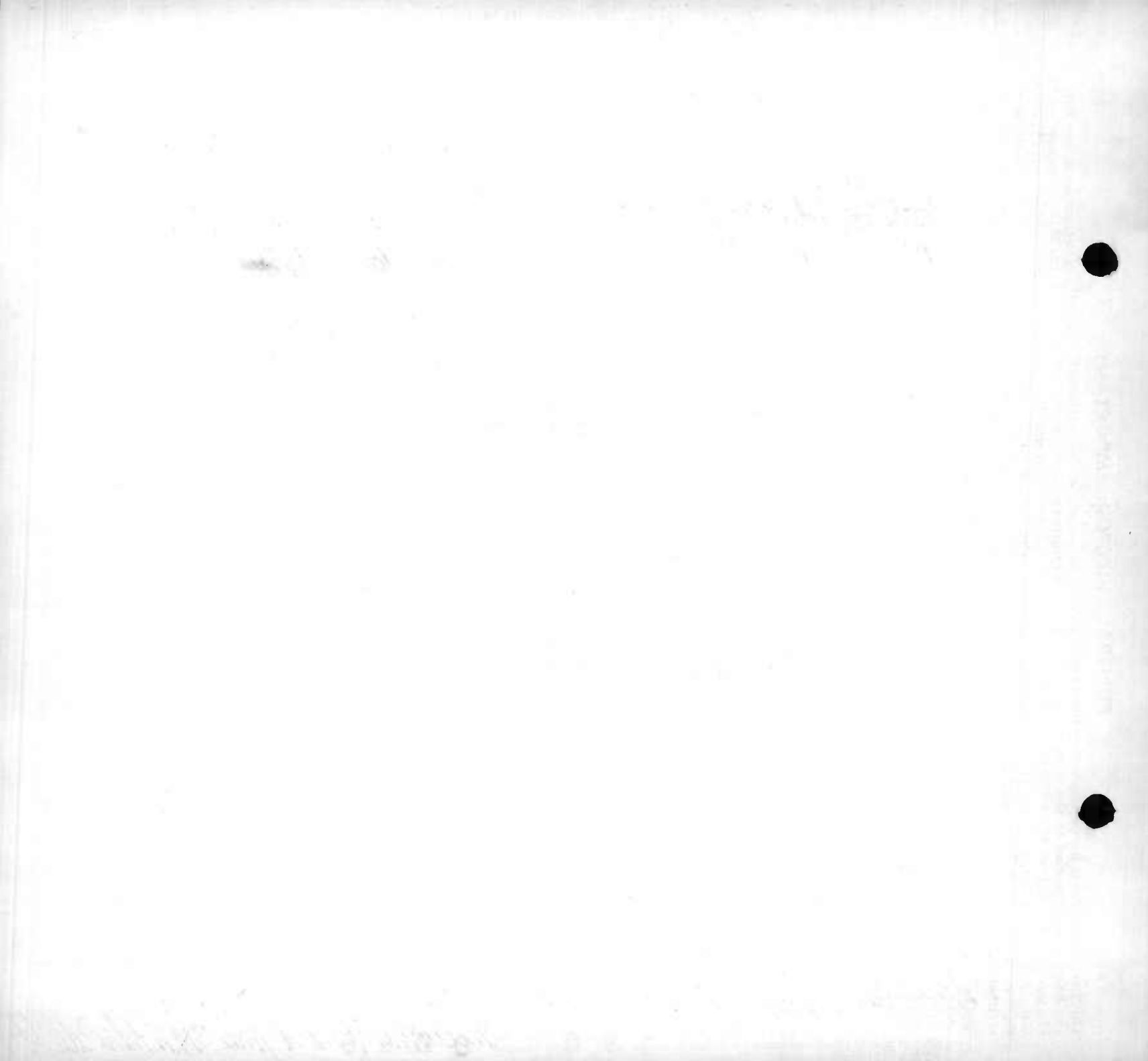
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0867

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 0867

BIRTH NO.		REG. NO.		DOB	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
WILSON, ROBERT Sr.		1/22/69 12:10 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
UNIVERSITY HOSPITAL REDWOOD & GREENE STS BALTO, MD. 21201		C. CITY OR TOWN D. INSIDE CITY LIMITS?			
8 UNIVERSITY HOSPITAL REDWOOD & GREENE STS BALTO, MD. 21201		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX M		6. RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
				7/26/06	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)	
Laborer				62	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		11 Under 1 Yr. Months Days 11 Under 24 Hrs. Hours Min.	
Va.		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Erasmus Wilson		Sally Scarborough			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
2 unknown		215-05-7136		Admission Sheet	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Myocardial INFARCTION WITH TERMINAL		hours	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION LAST		DUE TO, OR AS A CONSEQUENCE OF:			
		(B) CONGESTIVE HEART FAILURE		170	
		(C) ARTERIO-SCLEROTIC CARDIOVASCULAR DIS.		Years	
II		PNEUMONIA		170	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
		2			
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
YES					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1/24/68 to 1/22/69 that (I) (we) last saw the deceased alive on JAN 22, 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Noel Mayer Cherry, M.D.				12/22/69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Noel Mayer Cherry, M.D.				University Hospital, Balto, MD	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		1/27/69		Mt. Auburn Cem	
24D. LOCATION (City, town or county) (State)		24E. FUNERAL DIRECTOR		24F. ADDRESS	
Balto. MD		William J. ...		377 N. ...	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0868		BALTIMORE CITY HEALTH DEPARTMENT		X		69 0868	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>James H. Pickel</u>				2. DATE AND HOUR OF DEATH <u>1/23/69</u> <u>1:53</u> <u>P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Johns Hopkins Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Del.</u> B. COUNTY <u>Newcastle</u> V-07			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Johns Hopkins Hospital</u>				C. CITY OR TOWN <u>Wilmington</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>Veterans Hospital</u>							
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/17/17</u>	9. AGE (in years last birthday) <u>51</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work depending on most of working life, even if retired) <u>Hospital administrator</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>Phoenixville, Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Howard Pickel</u>				14. MOTHER'S MAIDEN NAME <u>Finney Sadie Finney</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes Navy WWII</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Wife</u> ADDRESS <u>same as deceased</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Meta static cancer of bladder</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 mos.</u>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>1.6.68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>1.6.68 of bladder &amp; lymph. lap.</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, home, lot, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>1/4</u> 19 <u>69</u> to <u>1/23</u> 19 <u>69</u> that (1) (we) last saw the deceased alive on <u>1/23</u> 19 <u>69</u> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Robert S. Kurtz</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1/23/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>Robert S. Kurtz</u>				23D. ADDRESS <u>Johns Hopkins Hospital Balt. Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1/27/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>St. James Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Wilmington, Del.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 24 1969</u>		25B. NAME OF REGISTRAR <u>Robert S. Kurtz</u>		25C. FUNERAL DIRECTOR <u>McCary Funeral Home, Wilmington, Delaware.</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 69 0869 CERTIFICATE OF DEATH

REG. NO. 69 0869

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>LUCILLE E. BEAULAC</b>		2. DATE AND HOUR OF DEATH <b>1-23-69 11:35 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>27-06</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION MEMORIAL HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>8829 BEECHLAND AVE.</b>		5. SEX <b>F</b>		6. RACE <b>W</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>5-26-06</b>		9. AGE (In years last birthday) <b>62</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>CANADA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>EDWARDS ST DENIS</b>		14. MOTHER'S MAIDEN NAME <b>JOSEPHINE BESNER</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-38-5949</b>		17. INFORMANT <b>Mrs. Jeanette Tideman</b>	
18. <b>15-9 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>CARCINOMA OF THE</b> DUE TO, OR AS A CONSEQUENCE OF: <b>GASTROINTESTINAL TRACT METASTASIS.</b> (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>1969</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan. 22 1969</b> to <b>Jan. 23 1969</b> , that (I) (we) last saw the deceased alive on <b>Jan. 23 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Rogelio S. Mupas M.D.</b>		23B. DATE SIGNED <b>1-23-69</b>		23C. PHYSICIAN'S NAME (Type) <b>Rogelio S. Mupas M.D.</b>	
23D. ADDRESS <b>Union Memorial Hospital</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/27/69.</b>		24C. NAME OF CEMETERY or CREMATORY <b>Parkwood Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		24E. (State)			
25A. DATE RECEIVED BY HEALTH DEPT. <b>JAN 24 1969</b>		25B. NAME OF REGISTRAR <b>Leonard J. Ruck</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>	

4 11 11

Carlson, James

1944-1945

1944-1945

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>69 0870</b>
69 0870				CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>AL Fred Humber Salvette</b>		2. DATE AND HOUR OF DEATH <b>1-23-69 5:20 P.M.</b>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>St. Louis</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Pleasant Manor Nursing Home</b> <b>4615 Park Heights Ave</b> <b>BALTO. MARYLAND 21215</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <b>M</b> 6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 29, 1889</b> 9. AGE (In years last birthday) <b>79</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Salesman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>		11. BIRTHPLACE (State or foreign country) <b>Switzerland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John Salvette</b>		
14. MOTHER'S MAIDEN NAME <b>Barbara Sulser</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> WW 1		
16. SOCIAL SECURITY NO. <b>330-20-5536</b>		17. INFORMANT <b>Mrs Freida Little</b> ADDRESS <b>Same</b>		
18. I <b>1621</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Bronchogenic Carcinoma</b> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>1-7-1969</b> to <b>1-23-1969</b> , that (I) (we) last saw the deceased alive on <b>1-23-1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Frank G. Kuehn</b>		23B. DATE SIGNED <b>1-23-69</b>		23C. PHYSICIAN'S NAME (Type) <b>FRANK G. KUEHN</b>
23D. ADDRESS <b>721 MED ARTS BLDG. BALTO. MD</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>1/25/69</b>		24C. NAME of CEMETERY or CREMATORY <b>Moreland Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE RECEIVED BY HEALTH DEPT. <b>1/25/69</b>		25B. NAME OF REGISTRAR <b>Leonard J Ruck Inc.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Baltimore, Maryland</b>

Page 10

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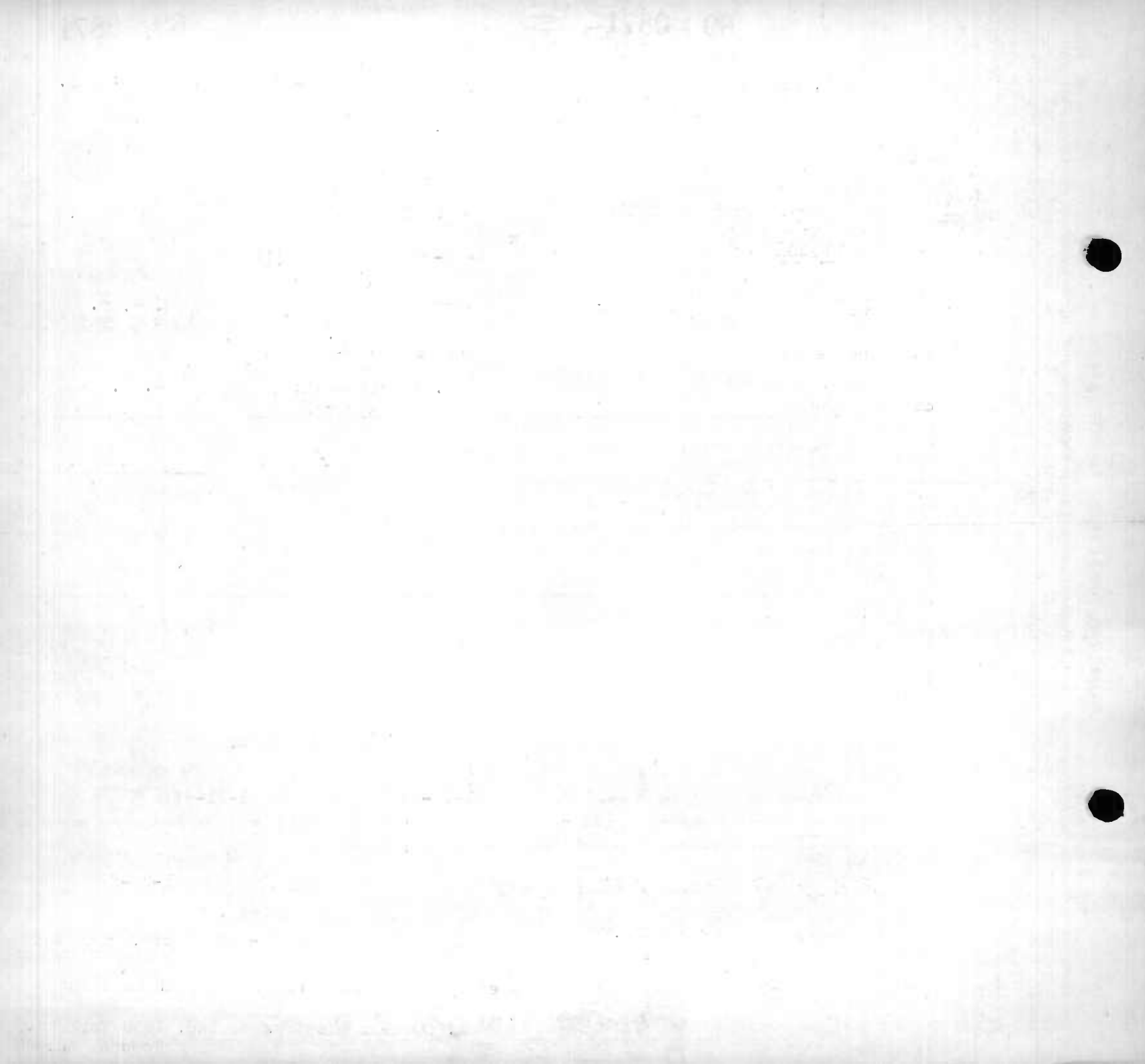
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">69 0871</span>
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Lewis, Joseph Frank</b>		2. DATE AND HOUR OF DEATH <b>1-21-69 8:55 p.</b> M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>39 Provident Hospital 1514 Division Street Baltimore, Maryland 21217</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>6-17-23</b>		9. AGE (In years lost birthday) <b>45</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Man Power</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Olzder Lee Lewis</b>		
14. MOTHER'S MAIDEN NAME <b>Madie Unis Webb</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW 11</b>		
16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Mrs. Maddie Lewis (Mother)</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Abdominal - D T</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>1-19-69</b> to <b>1-21-69</b> that (I) (we) last saw the deceased alive on <b>1-21-69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Roland T. Smoot, M.D.</b>		23B. DATE SIGNED <b>1-22-69</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <b>ROLAND T. SMOOT, M.D.</b>		23D. ADDRESS <b>Provident Hospital 1514 Division Street - Baltimore, Maryland</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-24-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Macclesfield Cemetery</b>
24D. LOCATION <b>Macclesfield North Carolina</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>		
25B. NAME OF REGISTRAR <b>W. Cook</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Brooks Towson, Inc. 1050 York Rd. Towson, Md.</b>		





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>DORIS BUTTON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input checked="" type="checkbox"/> Month <b>1</b> Day <b>22</b> Year <b>69</b> Hour <b>11:30</b> a. <b>M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>00 4711 Hampnett</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month <b>January</b> Day <b>22</b> , Year <b>1969</b> Hour <b>11:30</b> a. <b>M.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>27-02</b>			
6. SEX <b>Female</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. DATE OF BIRTH <b>April 24, 1921</b>		10. AGE (In years lost birthday) <b>47</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF <b>U.S.A.</b>	
13. FATHER'S NAME <b>Clarence H. Button</b>		14. STREET AND NUMBER <b>4711 Hampnett</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sect'y.</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>	
15. MOTHER'S MAIDEN NAME <b>Hilda N. Newber</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>215-14-4250</b>	
18. INFORMANT <b>Wm. H. Button, 1303 Warwick Rd. Lutherville</b>		ADDRESS	
19. <b>412.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH <b>Hypertensive arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>No</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Edward F. Wilson</b> M.D. EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1/22/69</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>Jan. 25, 1969</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Moreland Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>		25B. NAME OF REGISTRAR <b>Wm. Cook-Brooks</b>	
25C. FUNERAL DIRECTOR <b>Towson, 1050 York Road</b>		ADDRESS <b>Towson, Md. 21204</b>	

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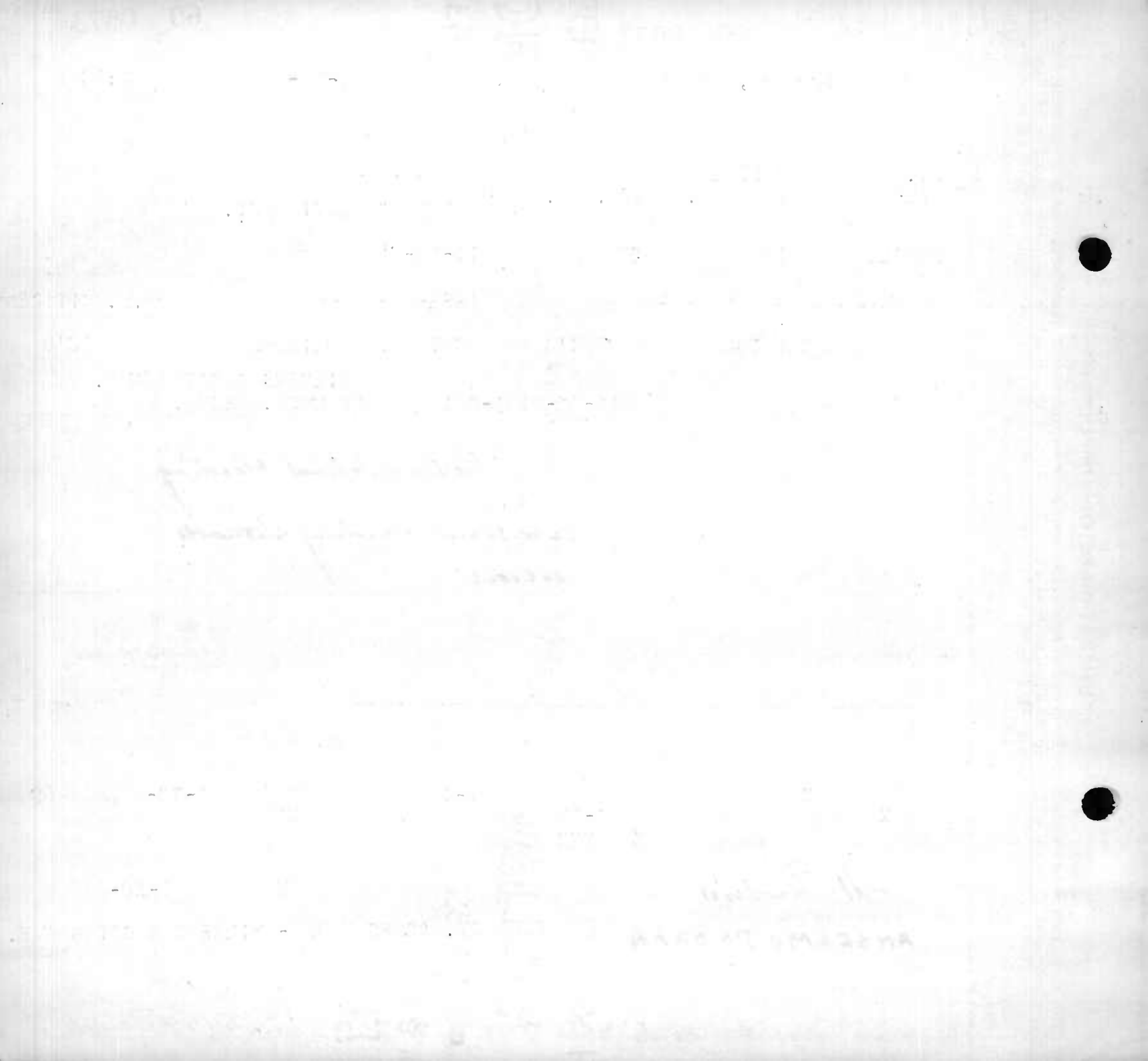
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

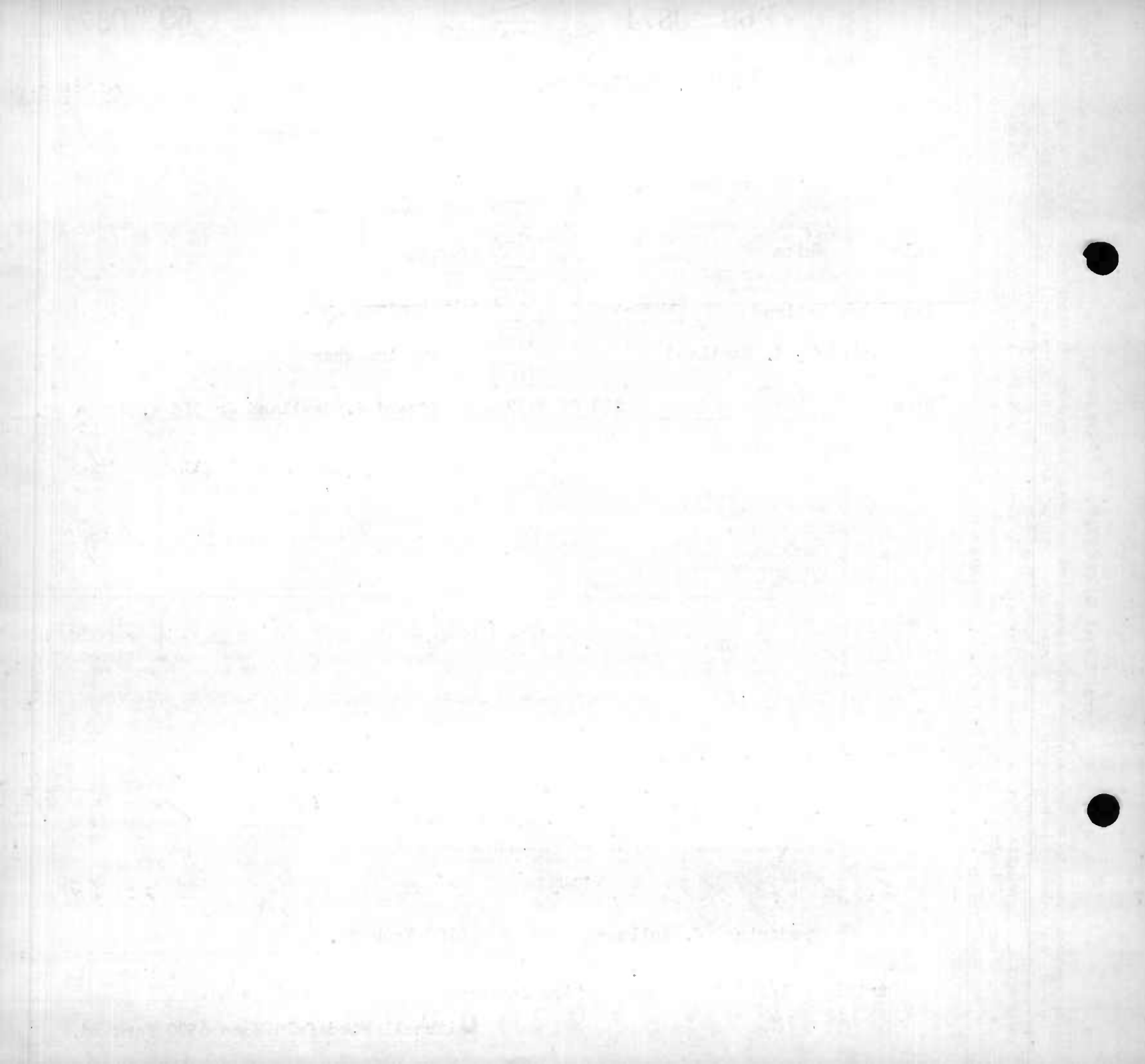
BIRTH NO. 69 0873				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 0873			
1. NAME OF DECEASED (Type or Print) <b>SWEENEY, ANNA ANN M. SWEENEY</b>				2. DATE AND HOUR OF DEATH <b>1-20-69 7:45 A M.</b>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST. AGNES HOSPITAL WILKENS &amp; CATON AVE. BALTO. MD. 21229</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>20-05</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2531 CHRISTIAN ST.</b>							
5. SEX <b>FEMALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-19-81</b>		9. AGE (In years lost birthday) <b>88 87</b>		10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HSWF</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>				11. BIRTHPLACE (State or foreign country) <b>IRELAND</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S. CITIZEN</b>				13. FATHER'S NAME <b>John MARTIN CLINTON</b> DEC'D				14. MOTHER'S MAIDEN NAME <b>CATHERINE CLINTON</b> DEC'D			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>X No</b>				16. SOCIAL SECURITY NO. <b>212-05-6103</b>				17. INFORMANT <b>WILKENS &amp; CATON AVE. SAINT AGNES HOSP. RECORD ROOM</b>			
18. <b>531.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(A) IMMEDIATE CAUSE <b>Gastrointestinal bleeding</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) <b>Subarachnoid bleeding stomach</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) <b>relaxed</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION <b>2</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from <b>1-19</b> 19 <b>69</b> to <b>1-20</b> 19 <b>69</b> , that (X) (we) last saw the deceased alive on <b>1-20</b> 19 <b>69</b> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.											
23A. SIGNATURE <b>A. Paulin</b>				23B. DATE SIGNED <b>1-20-69</b>							
23C. PHYSICIAN'S NAME (Type) <b>ANSELMO PADRON</b>				23D. ADDRESS <b>ST. AGNES HOSP - WILKENS &amp; CATON AVE.</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>				24B. DATE <b>1-23-69</b>				24C. NAME OF CEMETERY or CREMATORY <b>NEW CATHEDRAL</b>			
24D. LOCATION (City, town, or county) (State) <b>BALTO., Md.</b>											
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1969</b>				25B. NAME OF REGISTRAR <b>Paul S. Johnson</b>				25C. FUNERAL DIRECTOR <b>J. Stalter</b>			
								ADDRESS <b>5444 BELAIR RD.</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">69 0874</span>	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Edward J. Haviland Sr.</b>				1/19/1969 <span style="float: right;">10:30 A. M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 437 Evesham Ave.</b>				A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> <span style="float: right;">27-12</span>	
				C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>437 Evesham Ave</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/6/1896</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Handy Man Retired</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Beverage</b>		11. BIRTHPLACE (State or foreign country) <b>Wilmington, Del.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Patrick H. Haviland</b>		
14. MOTHER'S MAIDEN NAME <b>Mary Creaghan</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>None</b>		
16. SOCIAL SECURITY NO. <b>228 07 8437 A</b>			17. INFORMANT ADDRESS <b>Edward J. Haviland Jr 515 W. Joppa Rd.</b>		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>410.9 + 1 470 X</b>					
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Recurrent myocardial infarct</b> <span style="float: right;">1 hr</span>					
(B) <b>Coronary atherosclerotic heart disease</b> <span style="float: right;">6+ yrs</span>					
(C) _____					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Influenza</b> <span style="float: right;">2 wks</span>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>May 6 1963</b> to <b>Jan 14 1969</b> , that (I) <del>was</del> lost saw the deceased alive on <b>Jan 7 1969</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) <del>did not</del> view the body after death.					
23A. SIGNATURE <b>Frederick J. Vollmer MD</b>				23B. DATE SIGNED <b>1-20-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Frederick J. Vollmer</b>				23D. ADDRESS <b>6100 York Rd.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/21/69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Pikesville Md.</b>		24E. STATE (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Mitchell W. Wedefeld Home 6500 York Rd.</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 0875

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>ELEANOR MUSSELLMAN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>January 20, 1969</b> <b>11:20 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 9 W. Melrose (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 20, 1969 11:20 A.M.</b>	
6. SEX <b>Female</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>27-12</b>	
9. DATE OF BIRTH <b>October 25, 1904</b>		10. AGE (In years last birthday) <b>64</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Howard J. Musselman</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>homemaker</b>	
15. MOTHER'S MAIDEN NAME <b>Nellie Shaw</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>	
17. SOCIAL SECURITY NO. <b>220-40-2069</b>		18. INFORMANT <b>John T. Coady 101 E. Redwood St. #21202</b>	
19. CAUSE OF DEATH <b>413.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1/20/69</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>1/24/69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>		25B. NAME OF REGISTRAR <b>Mitchell-Wiedefeld</b>	
25C. FUNERAL DIRECTOR <b>Home 6500 York Rd. #21212</b>		25D. ADDRESS	

MAILING

Paul W. [Signature]



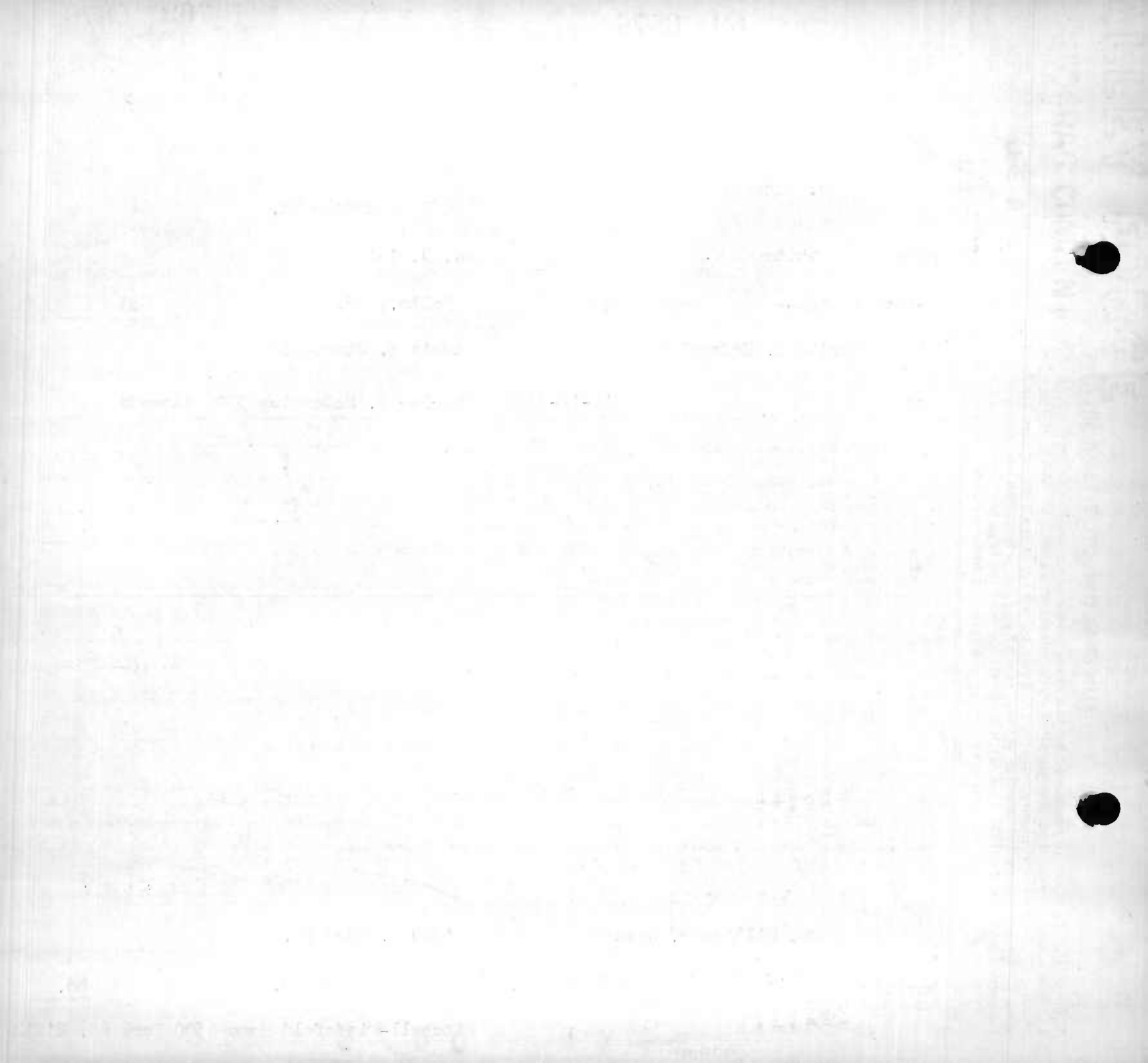
**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 69 0876 CERTIFICATE OF DEATH

REG. NO. 69 0876

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Charles E. McCormick, Jr.</b>		2. DATE AND HOUR OF DEATH <b>January 19, 1969</b> <b>12:30 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>48 Md. General Hosp.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-11</b>		C. CITY OR TOWN <b>Baltimore</b>	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>3402 Cedardale Rd.</b>	
5. SEX <b>male</b>	6. RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 4, 1916</b>	9. AGE (In years last birthday) <b>52</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>civil engineer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>State Roads</b>		11. BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Charles E. McCormick</b>		14. MOTHER'S MAIDEN NAME <b>Annie E. Utermohle</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-12-8226</b>		17. INFORMANT <b>Charles E. McCormick 3306 Alameda</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>410.0 I</b> <b>Acute myocardial infarction</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Hypertensive C-V disease + Anterior wall MI C-V disease</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b> <b>10 yrs.</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Feb. 7, 1957</b> to <b>Jan. 19, 1969</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Dec. 1, 1968</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) (We) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>W. H. Grenzer, M.D.</b>		23B. DATE SIGNED <b>1-21-69</b>			
23C. PHYSICIAN'S NAME (Type) <b>Dr. William H. Grenzer</b>		23D. ADDRESS <b>1520 E. 33rd St.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>	24B. DATE <b>1/22/69</b>	24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home 6500 York Rd. 21212</b>	



K-610

69 0877 BALTIMORE CITY HEALTH DEPARTMENT

69 0877

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>HARRY S. KIRBY</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> <b>January 16, 1969</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street, address, or location) <b>Muckett Hotel - 113 N. Paca St. Apt. 27</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 16, 1969 8:50 A. M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>March 1, 1918</b>		10. AGE (In years lost birthday) <b>50</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF <b>USA</b>	
13. FATHER'S NAME <b>Harry J. Kirby</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unk.</b>	
15. MOTHER'S MAIDEN NAME <b>May V.</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes WW II</b>	
17. SOCIAL SECURITY NO. <b>214-01-4987</b>		18. INFORMANT <b>Mrs. Margaret Kirby 6141 Chinquapin Pkwy.</b>	
19. CAUSE OF DEATH <b>481X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>(Partial) Yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>January 16, 1969</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>1/20/69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Balto. National Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbairn</b>	
25C. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home</b>		ADDRESS <b>6500 York Rd. 21212</b>	

V.S. 153

3-18-69

M.H.

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 0878
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Crissinger, Catherine L.</i>		2. DATE AND HOUR OF DEATH <i>1-22-69</i>   <i>6:12 A</i> M.	
3. PLACE IN BALTIMORE/MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> <span style="float: right;">5300</span>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>46</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Lutheran Hosp. of Maryland</i>		C. CITY OR TOWN <i>Essex 21221</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <i>845 Brunswick Rd</i>					
5. SEX <i>Fe</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-16-47</i>	9. AGE (In years last birthday) <i>21</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teller</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Bank- Union Trust Co. Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Judson J. Roach</i>		14. MOTHER'S MAIDEN NAME <i>Mildred Bass</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>224 70 2750</i>		17. INFORMANT <i>Leonard W. Crissinger</i> ADDRESS <i>Same</i>	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute Hemorrhagic Pericarditis</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1-21-1969</i> to <i>1-22-1969</i> , that (I) (we) last saw the deceased alive on <i>1-21-1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Norman Levin M.D.</i>		23B. DATE SIGNED <i>1-22-69</i>			
23C. PHYSICIAN'S NAME (Type) <i>NORMAN LEVIN, M.D.</i>		23D. ADDRESS <i>Bruzozinski Funeral Home 1407 Eastern Ave.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/25/69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holly Hill Memorial Gardens Baltimore Co., Md.</i>	
24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 27 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. [illegible]</i>		25C. FUNERAL DIRECTOR <i>Bruzozinski</i> ADDRESS	

104

Bank - Union Trust Co. 750-1111

Police

William Jones

Patricia J. Mason

2200 70 1250 Leonard A. Crawford - Bank

10

1250 70 1250 Leonard A. Crawford - Bank

10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. **69 0879**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>John Orem</b>		2. DATE AND HOUR OF DEATH <b>1-22-69 1:50 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 Bolton Hill Nursing &amp; Convalescent Center</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>13-06</b> C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3500 Chesnut Avenue</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-27-87</b>	9. AGE (In years last birthday) <b>81</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Produce Business</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Produce</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Unknown</b>			
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown. If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>214-14-3107</b>		17. INFORMANT ADDRESS <b>George W. Orem 9102 Vega Court Randallstown</b>			
18. <b>410.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Generalized Arteriosclerosis</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Several days</b> <b>Several yrs</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12-18-1968</b> to <b>1-22-1969</b> , that (I) (we) last saw the deceased alive on <b>1-22-1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>E. Ellsworth Cook</b>		23B. DATE SIGNED <b>1.22.69</b>		23C. PHYSICIAN'S NAME (Type) <b>E. Ellsworth Cook</b>	
23D. ADDRESS <b>2431 Mt. Ave.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>Jan. 24, 69</b>		24C. NAME of CEMETERY or CREMATORY <b>Western Cem. Balto. City</b>		24D. LOCATION (City, town, or county) (State) <b>Edmondson Ave. Balto City Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Stedman</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Loring Byers 38728 Liberty Rd. Randallstown</b>	



Concise and complete

49

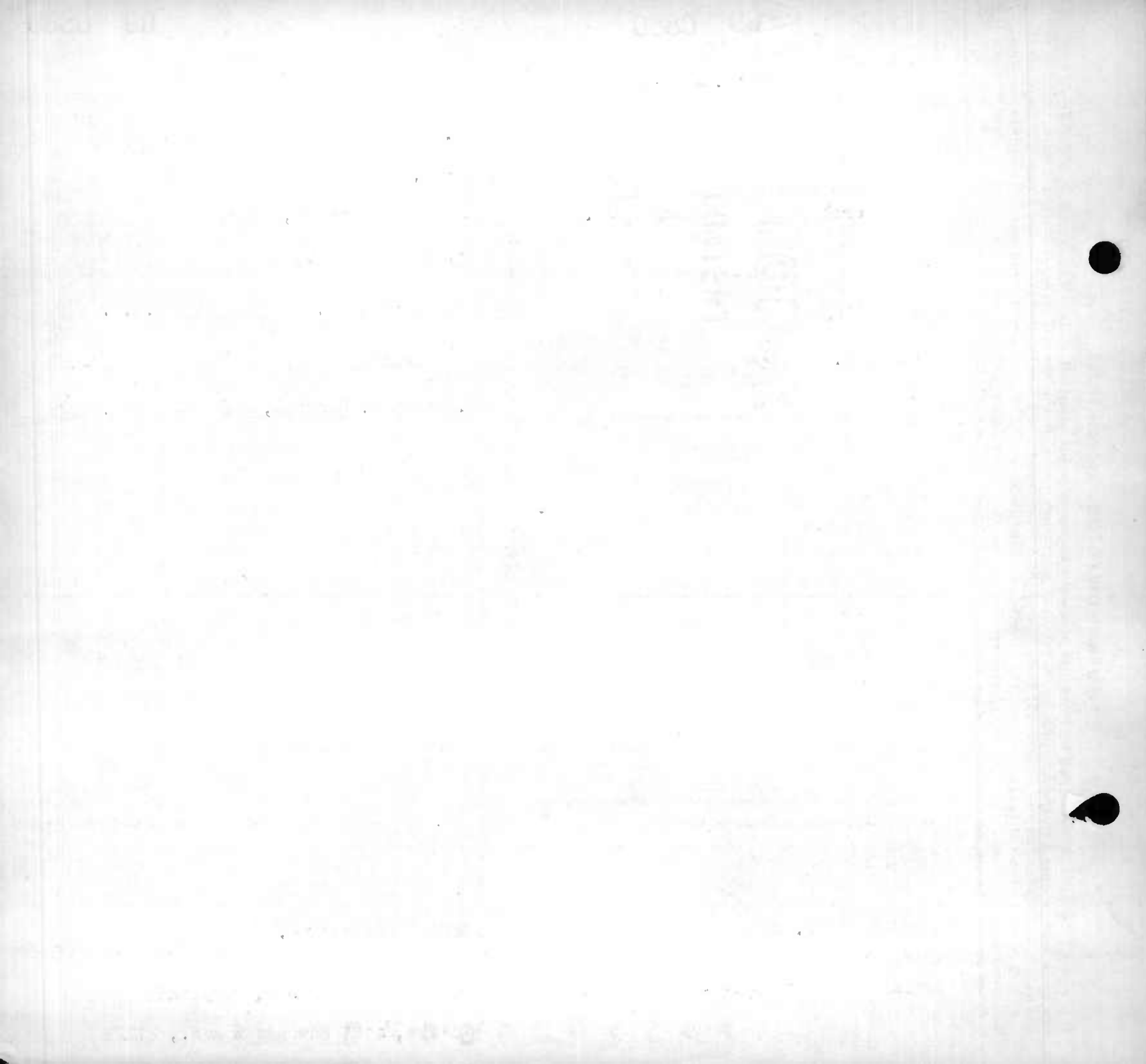
*[Faint, illegible handwriting]*



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">69 0880</span>
<p><b>BIRTH-NO.</b></p> <p><b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.1em;">Emma M. MARSTON</span></p>		<p><b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.1em;">1/25/69</span></p>		
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><span style="font-size: 1.2em;">90</span> Hood Nursing Home North Bend &amp; Edmondson Ave.</p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <span style="font-size: 1.1em;">Md.</span> B. COUNTY <span style="font-size: 1.2em;">28-64</span></p> <p>C. CITY OR TOWN <span style="font-size: 1.1em;">Balto.</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <span style="font-size: 1.1em;">408 Swann Avenue, 21229</span></p>		
<p><b>5. SEX</b> <span style="font-size: 1.1em;">Female</span></p>	<p><b>6. RACE</b> <span style="font-size: 1.1em;">White</span></p>	<p><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <span style="font-size: 1.1em;">4/1/89</span></p>	<p><b>9. AGE</b> (In years last birthday) <span style="font-size: 1.1em;">79</span></p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.1em;">Saleslady</span></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b></p>		
<p><b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.1em;">Baltimore, Md.</span></p>		<p><b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.1em;">U.S.A.</span></p>		
<p><b>13. FATHER'S NAME</b> <span style="font-size: 1.1em;">James H. Marston</span></p>		<p><b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.1em;">Anna</span></p>		
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p><b>16. SOCIAL SECURITY NO.</b></p>		<p><b>17. INFORMANT ADDRESS</b> <span style="font-size: 1.1em;">Mr. Harry H. Marston, 408 Swann Ave. 21229</span></p>
<p><b>18. CAUSE OF DEATH</b></p> <p><span style="font-size: 1.2em;">157.91</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p style="text-align: center;"><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.1em;">CAPSULES - S. MARSTON</span></p> <p>(B) <span style="font-size: 1.1em;">P. O. U. D.</span> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) <span style="font-size: 1.1em;">HYPERTHYROIDISM</span></p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>				
<p><b>MEDICAL CERTIFICATION</b></p> <p>19A. DATE OF OPERATION <span style="font-size: 1.1em;">1/25/69</span> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> <p>20A. AUTOPSY? (Yes or No) <input type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p> <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> <p>21F. HOW DID INJURY OCCUR?</p> <p>22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.1em;">1/25</span> 19 <span style="font-size: 1.1em;">52</span> to <span style="font-size: 1.1em;">1/28</span> 19 <span style="font-size: 1.1em;">69</span>, that (I) (we) last saw the deceased alive on <span style="font-size: 1.1em;">1/25</span> 19 <span style="font-size: 1.1em;">69</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> <p>23A. SIGNATURE <span style="font-size: 1.1em;">John H. Shaw</span> 23B. DATE SIGNED <span style="font-size: 1.1em;">1/26/69</span></p> <p>23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.1em;">Dr. Shaw</span> 23D. ADDRESS <span style="font-size: 1.1em;">5800 Edmondson Ave.</span></p> <p>24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.1em;">Burial</span> 24B. DATE <span style="font-size: 1.1em;">1/28/69</span> 24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.1em;">Loudon Park Cemetery</span> 24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.1em;">Baltimore, Maryland</span></p> <p>25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.1em;">JAN 27 1969</span> 25B. NAME OF REGISTRAR <span style="font-size: 1.1em;">John H. Shaw</span> 25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.1em;">Mitche, 7410 Edmondson Ave., 21229</span></p>				



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
G-653 69 0881				69 0881	
<div style="display: flex; justify-content: space-between;"> <div> <p><b>BIRTH NO.</b></p> <p>1. NAME OF DECEASED (Type or Print) <i>Grant Anna</i></p> </div> <div> <p>2. DATE AND HOUR OF DEATH <i>1-24-69 12:45 P.M.</i></p> </div> </div>					
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Bon Secours Hospital</i></p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <i>md.</i> B. COUNTY <i>Balto.</i></p> <p>C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>E. STREET AND NUMBER <i>6148 Regent Park Road</i></p>		
<p>5. SEX <i>Female</i></p>	<p>6. RACE <i>white</i></p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <i>2/15/86</i></p>	<p>9. AGE (In years last birthday) <i>82</i></p>	<p>If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) <i>Maryland</i></p>	
<p>13. FATHER'S NAME <i>EDWARD BUNTING</i></p>			<p>14. MOTHER'S MAIDEN NAME <i>ANNIE SCHAEFFER</i></p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO. <i>---</i></p>	<p>17. INFORMANT ADDRESS <i>Mrs. William Franco, 6148 Regent Park Drive</i></p>		
<p>18. <i>25-0-91</i> CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>MYOCARDIAL INFARCTION</i></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF: <i>A.S.C.V.D.</i></p> <p>(C) <i>DIABETES MELLITUS</i></p>					
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
<p>19A. DATE OF OPERATION <i>0</i></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) <i>NO</i></p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <i>1-21-1969</i> to <i>1-24-1969</i>, that (I) (we) last saw the deceased alive on <i>1-24-1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <i>[Signature]</i></p>				<p>23B. DATE SIGNED</p>	
<p>23C. PHYSICIAN'S NAME (Type) <i>BENITO MARTINEZ</i></p>				<p>23D. ADDRESS <i>BON SECOURS HOSPITAL</i></p>	
<p>24A. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i></p>		<p>24B. DATE <i>1/28/69</i></p>		<p>24C. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park Cemetery</i></p>	
<p>24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i></p>					
<p>25A. DATE REC'D BY HEALTH DEPT. <i>JAN 27 1969</i></p>		<p>25B. NAME OF REGISTRAR <i>[Signature]</i></p>		<p>25C. FUNERAL DIRECTOR ADDRESS <i>Edmondson Ave., 21229</i></p>	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 0882	
1. NAME OF DECEASED (Type or Print) <b>Alice B. ARNOLD</b>		2. DATE AND HOUR OF DEATH <b>1-24-69 - 8:27 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>BON SECOURS Hosp.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> <b>21229</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>BON SECOURS Hosp.</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <b>604 Stamford Rd - 28-54</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-28-93</b>	9. AGE (In years lost birthday) <b>75</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>WILLIAM M. GRAY</b>		14. MOTHER'S MAIDEN NAME <b>ALICE BELL</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-03-8057A</b>		17. INFORMANT <b>Mrs. Krieg, 510 N. Chapel Gate Lane</b>	
18. <b>410.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Recent myocardial infarct anterolateral wall of left ventricle</b> (B) <b>Coronary arteriosclerosis, extensive with occlusion</b> (C) <b>Arteriosclerotic heart disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1-22 1969</b> to <b>1-24 1969</b> , that (I) (we) last saw the deceased alive on <b>1-24 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b>		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <b>BENITO MARTINEZ</b>		23D. ADDRESS <b>BON SECOURS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/27/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>		25B. NAME OF REGISTRAR <b>[Signature]</b>		25C. FUNERAL DIRECTOR <b>[Signature]</b>	
25D. ADDRESS <b>Edmondson Ave. 21229</b>					

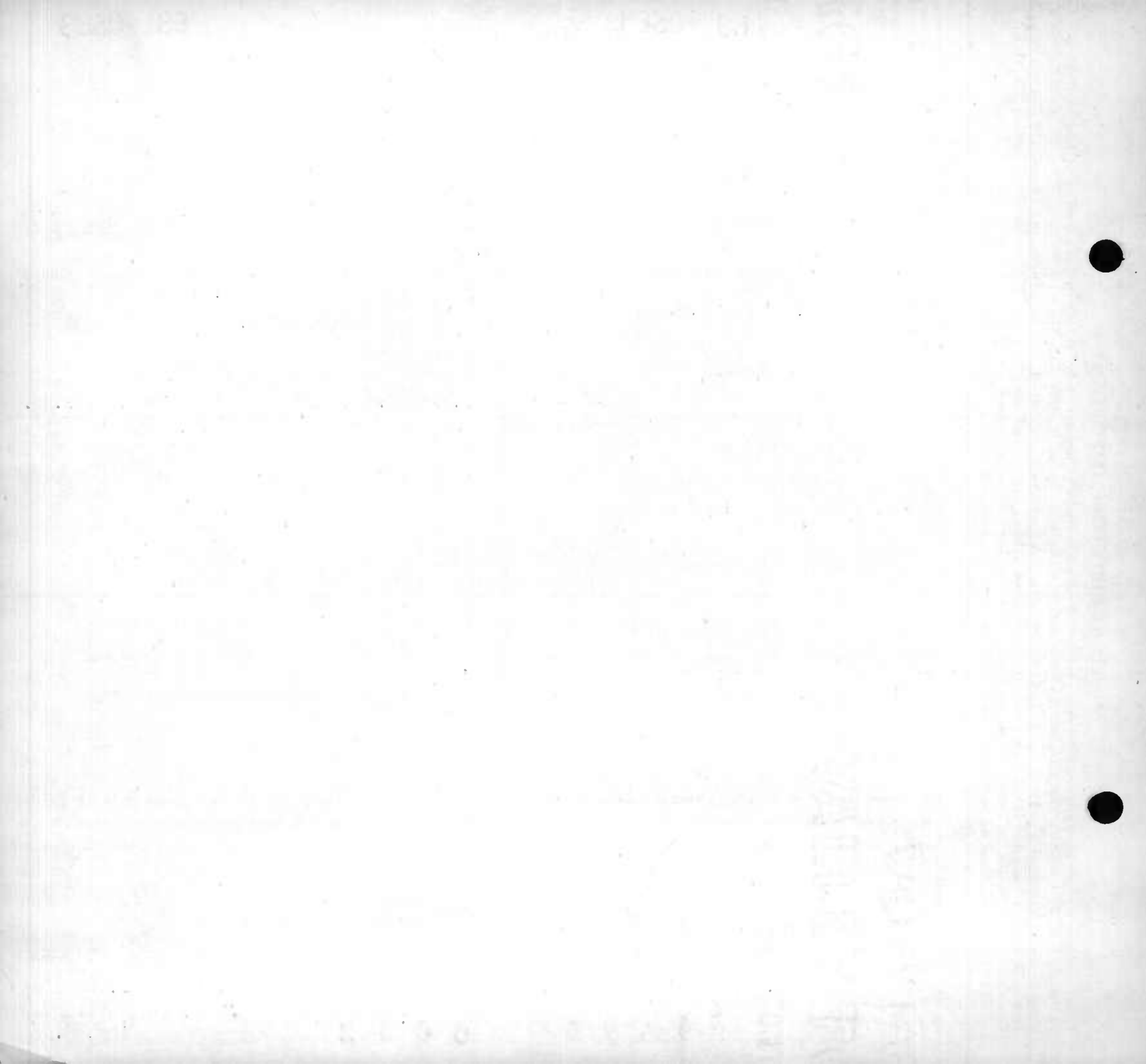


# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT  
**69 0883** **CERTIFICATE OF DEATH** REG. NO. **69 0883**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MILFORD GEORGE SMITH</b>		2. DATE AND HOUR OF DEATH <b>1-23-69 9:45 AM</b>		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>BON SECOURS HOSPITAL</b> <b>34</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/3/01</b>	
9. AGE (In years last birthday) <b>67</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Inspector</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ALBERT SMITH</b>				14. MOTHER'S MAIDEN NAME <b>WAGNER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-10-2044</b>		17. INFORMANT <b>Mrs. Ruth C. Smith, 324 Greenlow Road, Bal to. Md.</b>			
18. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CONGESTIVE HEART FAILURE</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>A-S-C-V-D</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 minutes</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C).....							
<b>II</b>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1-21-1969</b> to <b>1-23-1969</b> , that (I) (we) last saw the deceased alive on <b>1-23-1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>H. Makpouk</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>1/23/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>H - MAKPOUK</b>				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Jan. 27, 1969</b>		24C. NAME OF CEMETERY or CREMATORY <b>Crest Lawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Marriottsville, Howard Co., Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>		25B. NAME OF REGISTRAR <b>Obituary Registrar</b>		25C. FUNERAL DIRECTOR <b>Harry H. Witke, 321 Columbia Pike, Ellicott City, Md.</b>		ADDRESS	





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BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ROBINS PAULINE Anne</b>		2. DATE AND HOUR OF DEATH <b>1-20-69 5-30A M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTO.</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>CHURCH HOME AND HOSPITAL BALTIMORE MD. 21231</b>				C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>12. E. Mt. VERNON PL. 20002.</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7. 25. 07</b>	9. AGE (In years last birthday) <b>61</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SUPERVISOR U.S.F. &amp; G</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>U. S. F. &amp; G</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND.</b>	
13. FATHER'S NAME <b>AUGUSTA. J. ROBINS</b>				12. CITIZEN OF WHAT COUNTRY? <b>AMER.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>254 5512</b>		17. INFORMANT <b>V. Gangadharan</b> ADDRESS <b>100. N. Broadway Baltimore MD 21231</b>	
18. <b>412.31</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>URAEMIA.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic Heart Disease</b> <b>Months</b> <b>years.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-19-1968</b> to <b>1-20-1969</b> , that (I) (we) last saw the deceased alive on <b>1-19-1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>K. MARIANO</b>				23B. DATE SIGNED <b>1-20-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>J. C. MARIANO</b>				23D. ADDRESS <b>CHURCH HOME &amp; HOSP. BALTO. Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1-23-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>WOODLAWN Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>			
25B. NAME OF REGISTRAR <b>J. C. MARIANO</b>		25C. FUNERAL DIRECTOR <b>H. W. Fickner &amp; Sons</b> ADDRESS <b>BALTO. Md.</b>			

VALLEY FOLIO

CHURCH HOME AND HOSPITAL  
SOUTHWEST RD 2121

BRITAIN

13. C. MC KERNAN R. 50003

W 2

X 7. 25. 07 61

1955

MARKERS

SUPERVISOR U.S.A. 6 U.S.P. 26

ROBERTA T. ROBINSON

HUGHES W. 1918

100 N. Broadway  
Baltimore, Md.

224 2212 V. Langdon

1945

UKENIA

CONCEIVING HEART FAILURE  
Anticoagulant Heart Failure

1-19-19  
1-19-19  
1-19-19

1-19-19  
1-19-19  
1-19-19

CHURCH HOME AND HOSPITAL  
SOUTHWEST RD 2121

CHURCH HOME AND HOSPITAL  
SOUTHWEST RD 2121

100 N. Broadway  
Baltimore, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 69 0885 CERTIFICATE OF DEATH

REG. NO. 69 0885

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ROSE HURLEY</b>		2. DATE AND HOUR OF DEATH <b>JAN. 23, 1969 11:50 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>27-16</b>		C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 Ashburton House Nursing Home 3520 Hilton Rd Baltimore, Md.</b>		E. STREET AND NUMBER <b>3407 Woodland Ave.</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/28/1892</b>	9. AGE (In years last birthday) <b>96</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Samuel Kirkwood</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Ann Harmon</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <b>412.31</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		<b>Arteriosclerotic heart disease</b>		<b>unknown</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>JAN 21, 1964</b> to <b>JAN. 23, 1969</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>JAN. 23, 1969</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.					
23A. SIGNATURE <b>Abraham B. Hurwitz MD</b>		23B. DATE SIGNED <b>JAN. 24, 1969</b>		23C. PHYSICIAN'S NAME (Type) <b>ABRAHAM B. HURWITZ MD</b>	
23D. ADDRESS <b>7501 LIBERTY ROAD, BALTIMORE MD</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/25/69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>	
25B. NAME OF REGISTRAR <b>Robert S. Taylor</b>		25C. FUNERAL DIRECTOR <b>Wm. J. Teclan</b>		25D. ADDRESS <b>Balto, Md.</b>	



7-636

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>HARRIETT LEVENA PORTER</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>1 24 69 3:30 p.m.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>00 2025 W. North Ave.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 24, 1969 3:30 p.m.</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-02</b>	
6. SEX <b>Female</b>	7. RACE <b>Colored</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>Oct 18, 1886</b>		10. AGE (In years last birthday) <b>82</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) <b>Howard Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		E. STREET AND NUMBER <b>2025 W. North Ave.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Prob. Family</b>		13. FATHER'S NAME <b>Dennis P. Dorsey</b>	
15. MOTHER'S MAIDEN NAME <b>Frances A. ?</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>215-44-1286A</b>	
18. INFORMANT <b>Catherine Settles</b>		ADDRESS <b>4436 St. George Ave.</b>		19. <b>412.21</b> CAUSE OF DEATH <b>Hypertensive arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>No</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>[Signature]</b> M.D. EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1/25/69</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-28-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Nutter's Funeral Home</b>	
24D. LOCATION (City, town, or county) <b>Balto.</b>		24E. LOCATION (State) <b>Md.</b>		ADDRESS <b>3035 W. North Ave</b>	

8-25-80

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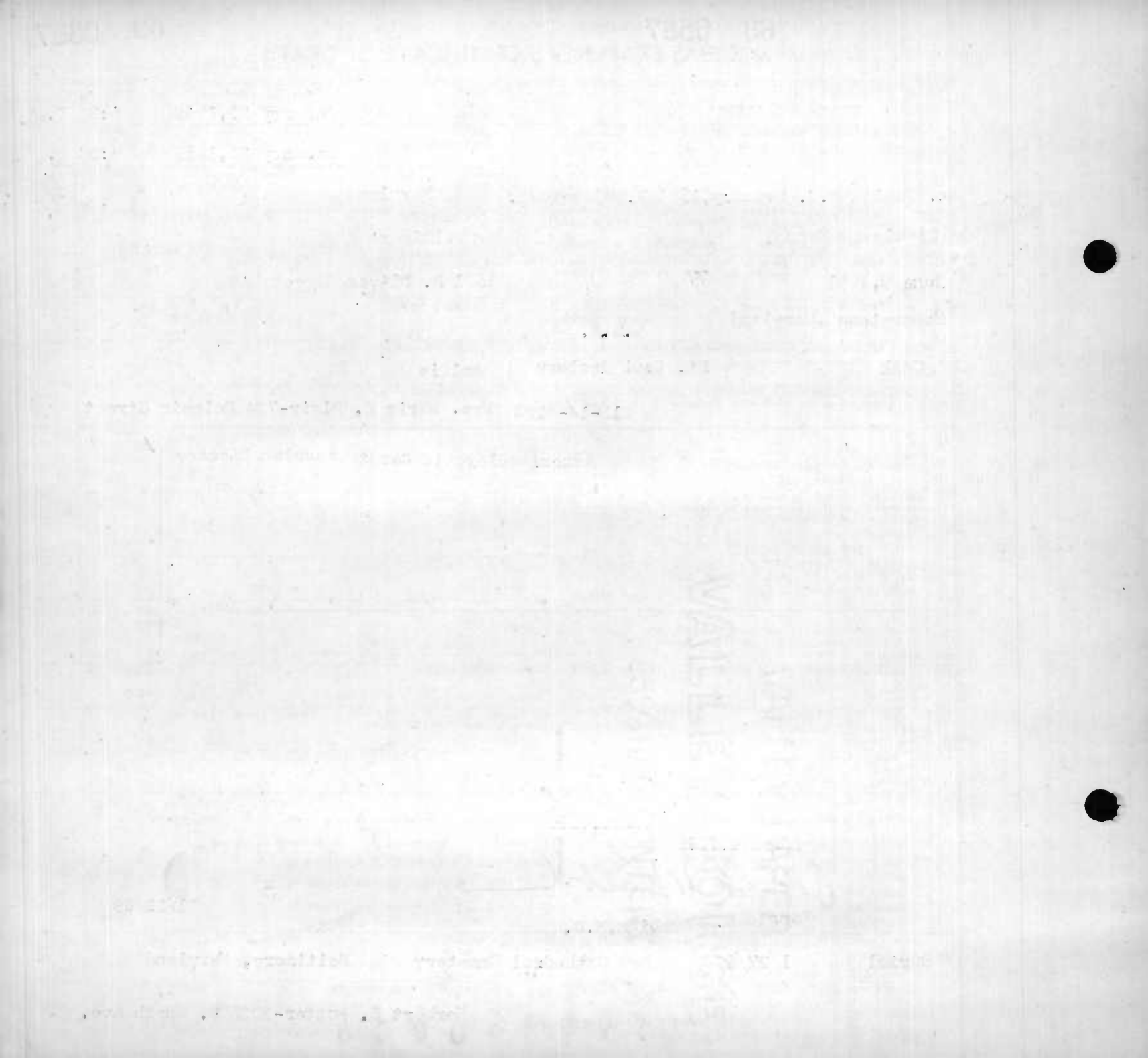
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69 0887 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 0887

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>GERTRUDE ALLEN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>January 23, 1969</b> <b>6:30 P.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) (DOA) <b>St. Paul's R.C. Rectory, 1501 E. Oliver St.</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>January 23, 1969</b> <b>6:30 P.M.</b>	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>June 9, 1891</b>		10. AGE (In years lost birthday) <b>77</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>St. Paul Rectory</b>	
15. MOTHER'S MAIDEN NAME <b>Mollie</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. <b>213-14-4224</b>		18. INFORMANT ADDRESS <b>Mrs. Marie E. Blair-724 Dolphin Street</b>	
19. <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH <b>Arteriosclerotic Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>1/23/69</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/27/69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>		25B. NAME OF REGISTRAR <b>Herbert E. Mutter-3035 W. North Ave.</b>	
25C. FUNERAL DIRECTOR		ADDRESS	







## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED

(Type or Print)

PAUL DOLFIELD KELLY

2. DATE  
OF  
DEATHKnown ☒  
Estimated ☐

Month

Day

Year

Hour

January 23, 1969

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Franklin Square Hospital (DOA)

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

January 23, 1969

1:05 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

6. SEX

Male

7. RACE

Negro

B. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

March 1, 1943

10. AGE (In years  
last birthday)

25

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

934 W. Fayette St.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Paul Russell

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Lebanese

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Fannie Reese

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Mary L. Kelly 3708 Flowerdown Rd.

19.

E9651

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Gunshot wound of chest  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

In front of 24 N. Poppleton

22D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
between 12:00 &  
1-23-69 12:30 A.

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Shot by unknown assailant during

altercation

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

January 23, 1969

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1/27/1969

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem. Balto. Md.

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 27 1969

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Williams Funeral Home

ADDRESS

319 N. Schenck St.

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>EUGENE GARNES</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 1 23 69 1:12 PM	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>D.O.A. Franklin Square Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 23, 1969 1:12 PM</b>	
6. SEX <b>Male</b>	7. RACE <b>Colored</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>16-01</b>
9. DATE OF BIRTH <b>Dec. 25, 1930</b>		10. AGE (In years last birthday) <b>38</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Joseph Barnes</b>		14. MOTHER'S MAIDEN NAME <b>Gertrude Davenport</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES Korean War</b>		18. SOCIAL SECURITY NO. <b>294-28-8870</b>	
19. INFORMANT <b>Gertrude Davenport</b>		ADDRESS <b>1115 Harlem Ave</b>	

1. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Fatty liver</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>ANTECEDENT CAUSES</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		

20A. DATE OF OPERATION <b>2</b>	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	21. AUTOPSY? (Yes or No) <b>YES</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR?

23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED
ACTUAL SIGNATURE <b>Edward F. Wilson</b> M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	

24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1/28/1969</b>	24C. NAME of CEMETERY or CREMATORY <b>St. Luke's Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 29 1969</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	25C. FUNERAL DIRECTOR <b>Williams Funeral Home</b>	ADDRESS <b>319 N. Schroeder St.</b>

03-10-1950  
The following is a list of the names of the persons who have been appointed to the various committees of the Board of Directors of the American Red Cross, for the year 1950-1951.

President: Mr. J. Edgar Hoover  
Vice President: Mr. J. B. Connelley  
Secretary: Mr. J. B. Connelley  
Treasurer: Mr. J. B. Connelley  
Committee on Administration: Mr. J. B. Connelley  
Committee on Public Relations: Mr. J. B. Connelley  
Committee on Finance: Mr. J. B. Connelley  
Committee on Legislation: Mr. J. B. Connelley  
Committee on Education: Mr. J. B. Connelley  
Committee on Research: Mr. J. B. Connelley  
Committee on Medical Services: Mr. J. B. Connelley  
Committee on Nursing Services: Mr. J. B. Connelley  
Committee on Voluntary Services: Mr. J. B. Connelley  
Committee on Public Health: Mr. J. B. Connelley  
Committee on Social Welfare: Mr. J. B. Connelley  
Committee on Civil Liberties: Mr. J. B. Connelley  
Committee on Human Rights: Mr. J. B. Connelley  
Committee on International Relations: Mr. J. B. Connelley  
Committee on Peace: Mr. J. B. Connelley  
Committee on War: Mr. J. B. Connelley  
Committee on Disarmament: Mr. J. B. Connelley  
Committee on Arms Control: Mr. J. B. Connelley  
Committee on Nuclear Energy: Mr. J. B. Connelley  
Committee on Space: Mr. J. B. Connelley  
Committee on the Environment: Mr. J. B. Connelley  
Committee on the Future: Mr. J. B. Connelley

Approved: J. Edgar Hoover  
Special Agent in Charge  
Federal Bureau of Investigation  
U. S. Department of Justice  
Washington, D. C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

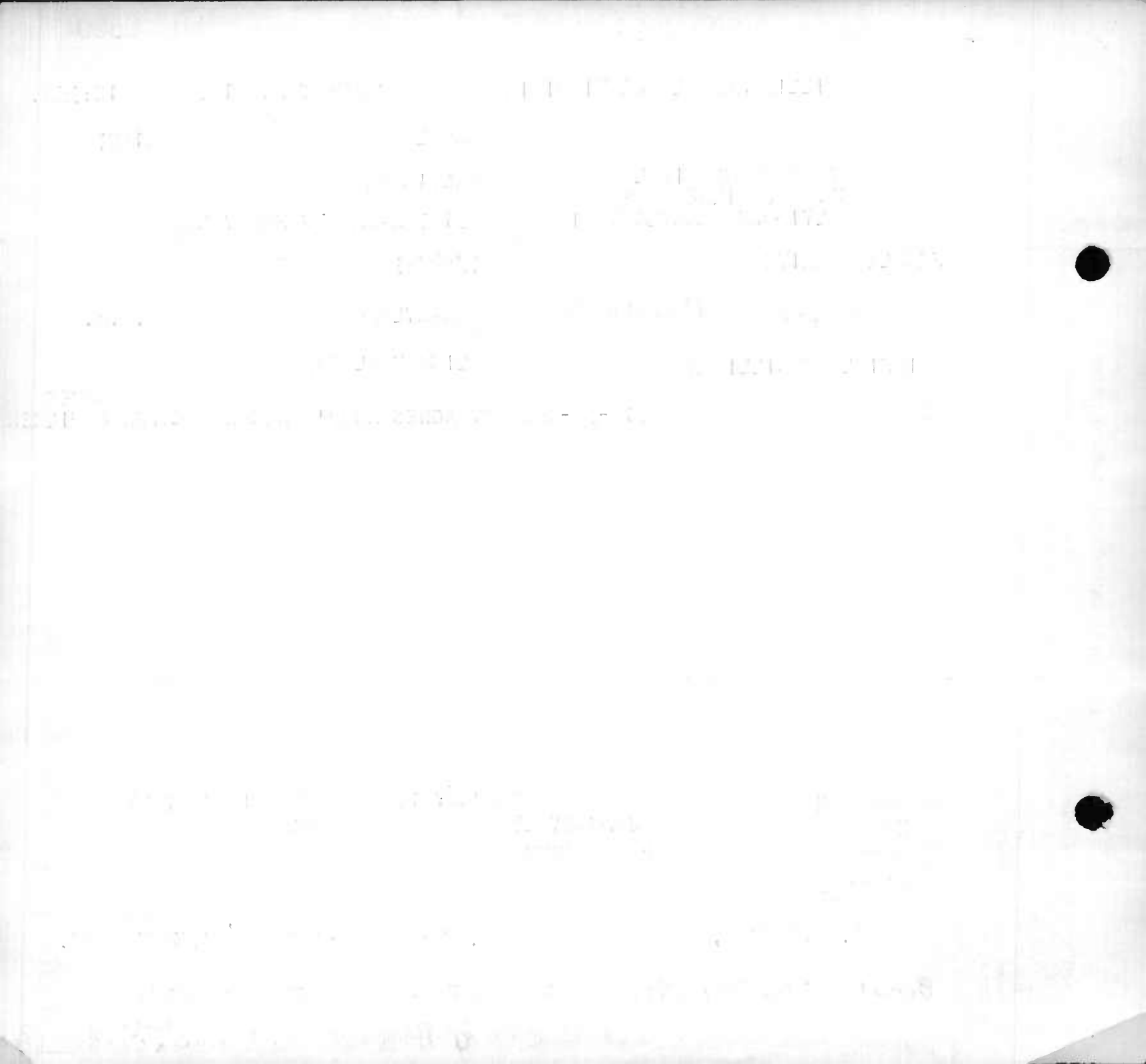
69 0890

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

69 0890

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>WILLINGHAN, LAURA VIRGINIA</b>		2. DATE AND HOUR OF DEATH <b>JANUARY 24, 1969 12:35A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Balti Co</b> <b>2122753-00</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>40 ST AGNES HOSPITAL CATON &amp; WILKENS AVENUES BALTIMORE, MARYLAND 21229</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>3107 HAMMONDS FERRY ROAD</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>07/04/83</b>	9. AGE (In years last birthday) <b>85</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Domestic Service</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>WINFIELD S WILLINGHAN</b>		14. MOTHER'S MAIDEN NAME <b>ALICE V ALEXANDER</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-30-9518</b>		17. INFORMANT <b>ST AGNES HOSP'S RECORDS CATON &amp; WILKENS</b>	
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CVA extensive</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx) <b>1</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <b>JANUARY 12</b> 19 <b>69</b> to <b>JANUARY 24</b> 19 <b>69</b> that (X) (we) last saw the deceased alive on <b>JANUARY 24</b> 19 <b>69</b> and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. PHYSICIAN'S SIGNATURE <b>R. Widmeyer MD</b>		23B. DATE SIGNED <b>1/24/69</b>		23C. ADDRESS <b>BALTO, MD 21229</b>	
23D. NAME (Type) <b>R. WIDMEYER, MD</b>		23E. ADDRESS <b>ST. AGNES HOSP; CATON &amp; WILKENS AVES.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-27-69</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Olivet Cemetery</b>	
24D. LOCATION <b>Baltimore, Md.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>		24F. NAME OF REGISTRAR <b>R. B. 29 Johnson</b>	
24G. FUNERAL DIRECTOR <b>Matthews Funeral Home</b>		24H. ADDRESS <b>3021 Eastern Ave</b>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 0891

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>MARIE T. FEEHLEY</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 1 21 69 4:24 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>411 Anglesea St. D.O.A.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 21, 1969 4:24 p.m.</b>	
6. SEX <b>Female</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE <b>White</b>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>October 3, 1894</b>		10. AGE (In years lost birthday) <b>74</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>House Work</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>None</b>	
15. MOTHER'S MAIDEN NAME <b>Mary Heckman</b>		18. INFORMANT <b>Winifred Bowen : 3922 Hudson St., Balto., Md.</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-25-69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>7225 Eastern Blvd., Ba. Co., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fegley</b>	
25C. FUNERAL DIRECTOR <b>Charles J. Zeiler</b>		ADDRESS <b>6224 Eastern Ave. Balto., 21224, Md.</b>	

FD 0201

69 0391

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

7

DATE 10-10-80 BY SP-5 JAC/STP

RECEIVED

10-10-80



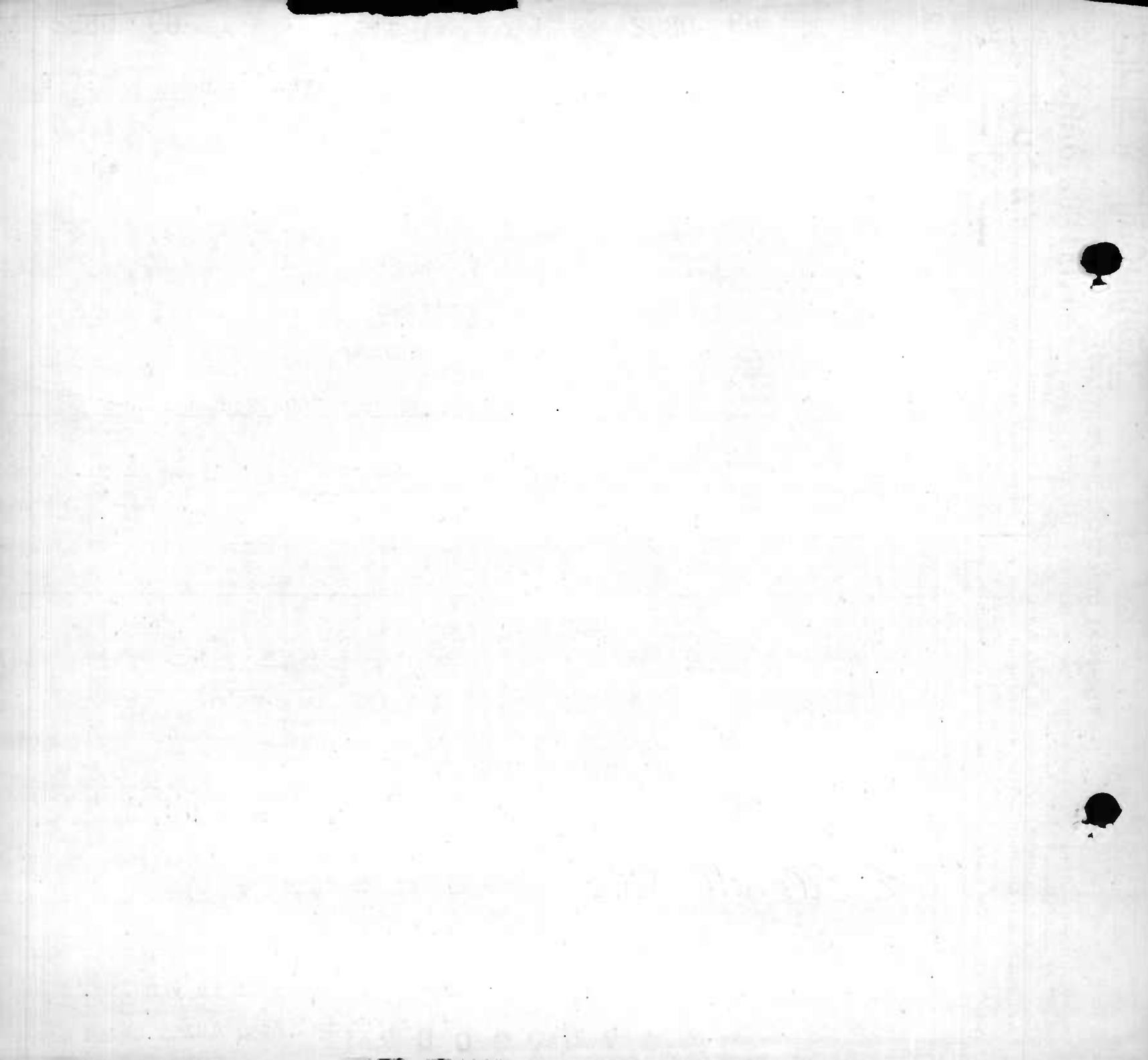
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0892 BALTIMORE CITY CERTIFICATE OF DEATH

REG. NO. 69 0892

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Richard J. Deisler		Jan. 21, 1969 1:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
90 1105 E. Fayette Street			Maryland C. CITY OR TOWN Baltimore E. STREET AND NUMBER 3904 Southern Ave.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months; Days If Under 24 Hrs. Hours Min.
M	W		6/21/1888	80	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
unknown		unknown		unknown	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
unknown			unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no none		213 09-7245A		Mrs. Melchor 3904 Southern Ave	
18. CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of Prostate 1 yr. (B) DUE TO, OR AS A CONSEQUENCE OF: (C)
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					Sev. Yrs
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from July 19, 1968 to Jan 21, 1969, that (I) (we) last saw the deceased alive on Jan 21, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE E Ellsworth Cook				23B. DATE SIGNED Jan 21, 1969	
23C. PHYSICIAN'S NAME (Type) E Ellsworth Cook MD.				23D. ADDRESS 2431 Maryland Ave	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1/22/69		Glen Haven Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 27 1969		Robert E. Jankovics		Krause Funeral Home 1216 S. Charles St	



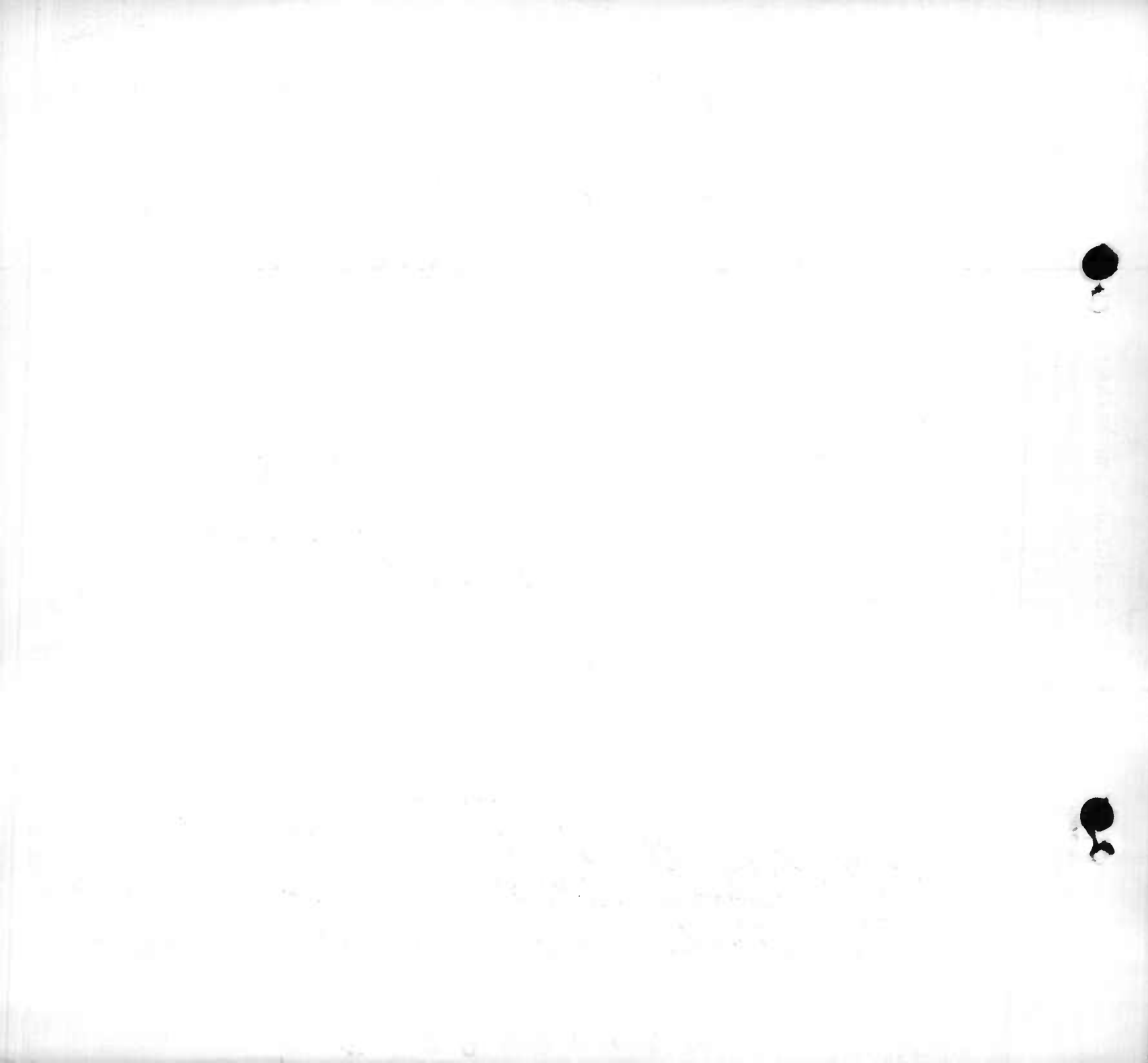
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0893

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 0893

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Hollander, Jeannette</i>		2. DATE AND HOUR OF DEATH <i>1/24/69 12:51 AM</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland.</i> B. COUNTY <i>27-30</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>H Sinai Hosp of Balt.</i>				C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>7111 Park Heights</i>	
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1/4/06</i>	9. AGE (in years last birthday) <i>63</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Jacob</i>				14. MOTHER'S MAIDEN NAME <i>Dora</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Malbert Hollander</i> ADDRESS <i>Same</i>	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  1 This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Shock</i>					
(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial Infarction</i>					
(C) <i>Septicemia</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1/23/69</i> 19 <i>69</i> to <i>1/24/69</i> 19 <i>69</i> that (I) (we) last saw the deceased alive on <i>12:51 AM 1/24/69</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>F. L. Goodman, M.D.</i>				23B. DATE SIGNED <i>1/24/69</i>	
23C. PHYSICIAN'S NAME (Type) <i>F. L. Goodman, M.D.</i>				23D. ADDRESS <i>Sinai Hosp of Balt.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/26/69</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Balto Hebrew</i>	
24D. LOCATION (City, town, or county) <i>Restestown</i>		24E. (State) <i>MD</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 27 1969</i>		25B. NAME OF REGISTRAR <i>John E. Stapp</i>		25C. FUNERAL DIRECTOR <i>Sylvan S. Lewis &amp; Son, Inc</i> ADDRESS <i>9610 Restestown Rd</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		BIRTH NO. 69 0894		CERTIFICATE OF DEATH		REG. NO. 69 0894	
1. NAME OF DECEASED (Type or Print) <b>LOUISE McMILLAN</b>				2. DATE AND HOUR OF DEATH <b>22 Jan 69 12 05 AM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>37 Mercy Hosp.</b>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		A. STATE <b>MD.</b>		B. COUNTY <b>BALTO</b>	
				C. CITY OR TOWN <b>ESSEX</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <b>394 NORTH RIVER DRIVE</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUG. 16, 1914</b>	9. AGE (In years last birthday) <b>54</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>S.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>BELTON SIMS JR</b>				14. MOTHER'S MAIDEN NAME <b>MINNIE KING</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNIK</b>		16. SOCIAL SECURITY NO. <b>247-01-1749</b>		17. INFORMANT <b>CARRIE BLANTON</b>		ADDRESS <b>ABOVE</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CIRRHOSIS of the LIVER alcoholic TYPE</b> (B) <b>Malnutrition - Chronic alcoholism</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>ASCVD</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Hemolytic anemia &amp; Thrombocytopenia etiology</b>							
19A. DATE OF OPERATION <b>1-4-69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>explor. Laparotomy</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>1 Jan 1969</b> to <b>22 Jan 1969</b> that (1) (we) last saw the deceased alive on <b>21 Jan 1969</b> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Salvatore R. Donohue MD</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>22 Jan 69</b>	
23C. PHYSICIAN'S NAME (Type) <b>SALVATORE R. DONOHUE MD</b>				23D. ADDRESS <b>MERCY HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1/24/69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>BEL AIR CEM</b>		24D. LOCATION (City, town, or county) (State) <b>BELAIR MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>		25B. NAME OF REGISTRAR <b>Robert J. Stachura</b>		25C. FUNERAL DIRECTOR <b>JO. CORNELLY</b>		ADDRESS <b>SONS 300 N. ACE</b>	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>36-06-60 <b>5-536</b> 69 0895 <b>CERTIFICATE OF DEATH</b> 69 0895</p>		<p>REG. NO. _____</p>	
<p>BIRTH NO. _____</p>		<p>1. NAME OF DECEASED (Type or Print) <b>MARY SCHNEIDER</b></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b></p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE</b> <b>BALTIMORE, MARYLAND 21224</b></p>		<p>C. CITY OR TOWN <b>ESSEX</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>5. SEX <b>FEMALE</b> 6. RACE <b>WHITE</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <b>2-20-05</b> 9. AGE (In years lost birthday) <b>63</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>		<p>11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b></p>	
<p>13. FATHER'S NAME <b>JOHN DITERS</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>ANNA SILVER</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNK</b></p>		<p>16. SOCIAL SECURITY NO. <b>216-05-4312</b></p>	
<p>17. INFORMANT <b>BCH: RECORDS 4940 EASTERN AVE. BALTO. MD.</b></p>		<p>ADDRESS <b>21224</b></p>	
<p>18. <b>410.91-250.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p>		<p>CAUSE OF DEATH</p>	
<p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p>		<p>(A) IMMEDIATE CAUSE <b>MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF: <b>14 hr.</b></p>	
<p>ANTECEDENT CAUSES</p>		<p>(B) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF: <b>2 yr.</b></p>	
<p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(C) _____</p>	
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Diabetes Mellitus</b></p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) <b>NO</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (1) (this hospital) attended the deceased from <b>1/20/69</b> 19 to <b>1/21/69</b> 19, that (1) (we) last saw the deceased alive on <b>1/21/69</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <b>David Ackerman M.D.</b> DEGREE</p>		<p>23B. DATE SIGNED <b>1/21/69</b></p>	
<p>23C. PHYSICIAN'S NAME (Type) <b>DAVID ACKERMAN M.D.</b> DEGREE</p>		<p>23D. ADDRESS <b>BALTIMORE CITY HOSPITALS 4940 EASTERN AVE BALTO. MD. 21224</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b> 24B. DATE <b>1/21/69</b></p>		<p>24C. NAME OF CEMETERY OR CREMATORY <b>BALTO. NATL.</b> 24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b></p>		<p>25B. NAME OF REGISTRAR <b>Robert E. Taylor</b> 25C. FUNERAL DIRECTOR <b>J. G. CONNELLY</b> ADDRESS <b>300 MACE</b></p>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 0896	
1. NAME OF DECEASED (Type or Print)		LINCK, ALICE ELIZABETH		2. DATE AND HOUR OF DEATH JANUARY 23, 1969 5:45 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		MARYLAND 21061 Anne Arundel 52-00	
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MD. 21229		C. CITY OR TOWN GLEN BURNIE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 1718 LEISURE LANE					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 06-20-84	9. AGE (In years lost birthday) 84	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME N. THOMAS GREEN		14. MOTHER'S MAIDEN NAME MARY ROLLINS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT BALTIMORE, MD. 21229 ADDRESS ST. AGNES RECORDS, WILKENS & CATON AVES	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Extension of CVA DUE TO, OR AS A CONSEQUENCE OF: (B) CVA DUE TO, OR AS A CONSEQUENCE OF: (C) Arteriosclerosis, generalized.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from JANUARY 14, 1969 to JANUARY 23, 1969 that (X) (we) last saw the deceased alive on JANUARY 23, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert Widmeyer, MD		23B. DATE SIGNED 1/23/69		23C. PHYSICIAN'S NAME (Type) ROBERT WIDMEYER, MD	
23D. ADDRESS WILKENS & CATON AVES.-BALTO., MD. 21229					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-27-1969		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
24D. LOCATION Woodlawn, Baltimore County, Md.					
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1969		25B. NAME OF REGISTRAR Howard H. Hubbard		25C. FUNERAL DIRECTOR ADDRESS 21229	

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# FUNERAL DIRECTOR: IMPORTANT

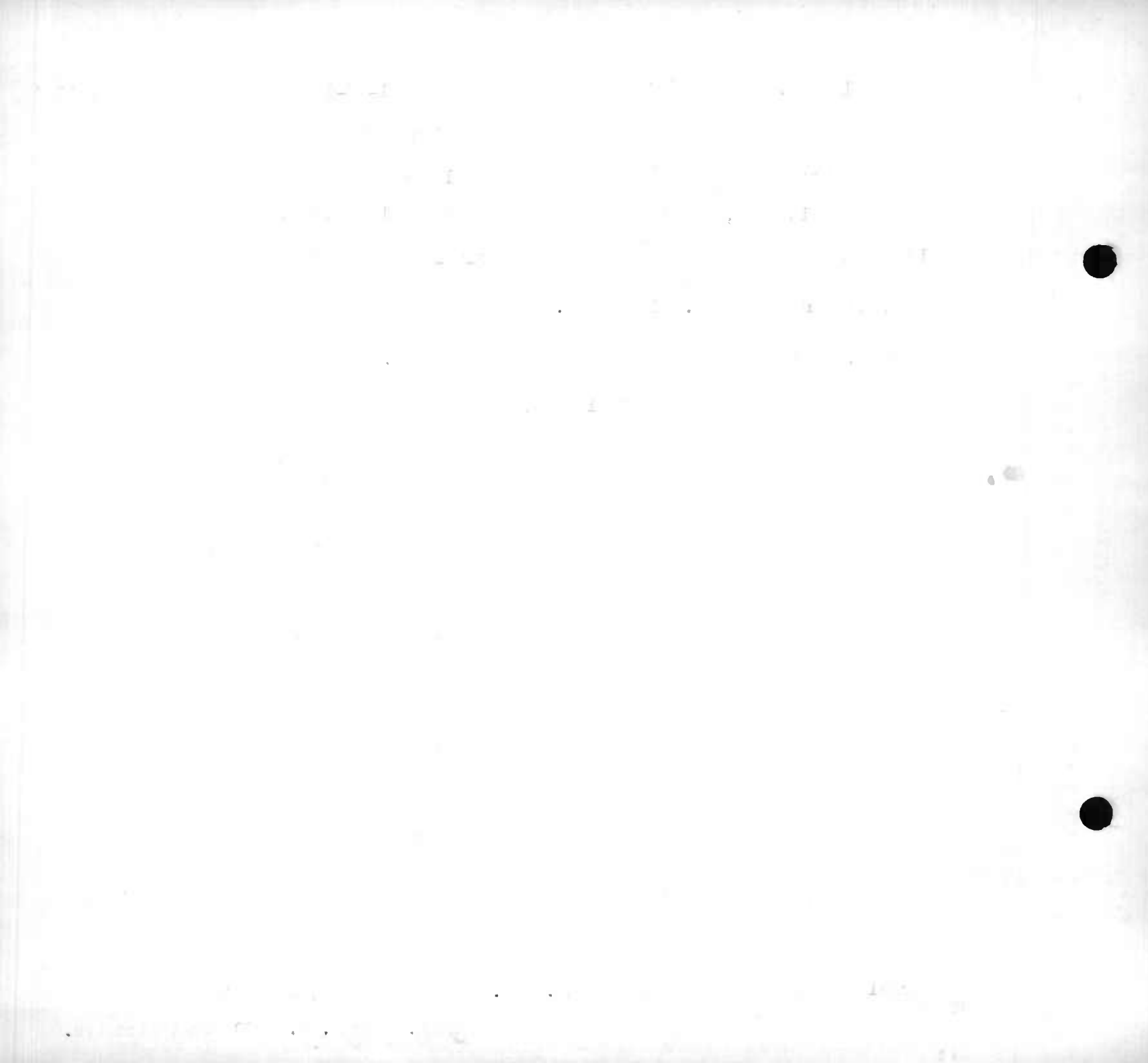
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 69 0897 CERTIFICATE OF DEATH

REG. No.

69 0897

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Lloyd O. Bowling (Bolling)</u>		2. DATE AND HOUR OF DEATH <u>1-25-69</u> <u>6:30 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>(21230)</u>		C. CITY OR TOWN <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>40</u> <u>St. Agnes Hospital</u> <u>Caton &amp; Wilkens Avenue</u> <u>Baltimore, Maryland 21229</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>2224 Berlin Street</u>	
5. SEX <u>Male</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-25-09</u>	9. AGE (In years last birthday) <u>59</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mold Polisher</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Md. Glass Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY		13. FATHER'S NAME <u>Amos A. Bolling</u>		14. MOTHER'S MAIDEN NAME <u>Martha J. Mennicks</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>227 18 3367</u>		17. INFORMANT <u>Family</u> ADDRESS <u>Same</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>410.9 I</u> <u>Myocardial Infarction</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary Insufficiency</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Atherosclerosis Cardiovascular</u> (C) <u>Hiatal Hernia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Hours.</u> <u>years.</u> <u>years.</u>	
19. DATE OF OPERATION <u>D</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Brailis O. France MD</u> DEGREE				23B. DATE SIGNED <u>1-25-69</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/29/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Bolling Fam. Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Pound, Virginia</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 27 1969</u>			
25B. NAME OF REGISTRAR <u>John B. Hahn</u>		25C. FUNERAL DIRECTOR <u>John B. Hahn</u> ADDRESS <u>4200 Pennington Ave.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0899

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 0899

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>HILDA I GREGG</b>		2. DATE AND HOUR OF DEATH <b>1-23-69 6:30 a.m.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE Co</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 BALTIMORE CITY HOSPITALS</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>4940 EASTERN AVENUE</b>		C. CITY OR TOWN <b>GLENARM</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>BALTIMORE, MARYLAND 21224</b>		<b>HILL RISE AVENUE</b>		E. STREET AND NUMBER	
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-14-17</b>	9. AGE (In years last birthday) <b>52</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Oliver Beard, SC</b>			
14. MOTHER'S MAIDEN NAME <b>Elizabeth Madden</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT ADDRESS <b>RECORDS-BCH-4940 EASTERN AVENUE, BALTIMORE, MD</b>			
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>carcinoma of the breast - metastases</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1967-1969</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Not by medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>1-21-1969</b> to <b>1-23-1969</b> , that (1) (we) lost saw the deceased alive on <b>1-23-1969</b> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>R. Christopher Stuckey MD</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>1-23-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>R. Christopher Stuckey</b>		23D. ADDRESS <b>4940 Eastern Avenue Baltimore, Maryland. Baltimore City Hospitals</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1/26/69</b>	24C. NAME OF CEMETERY or CREMATORY <b>Communit Baptist Ch.</b>		24D. LOCATION (City, town, or county) (State) <b>Joppa Harb. Co. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>		25B. NAME OF REGISTRAR <b>Edith E. Johnson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>1701 McCallum Baltimore, Md.</b>	

22

Workman

10

Because 1 paper Community Dept. in Japan. Prof. A. C. ...  
Wm. A. ...

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		A. BERTHA CHAPMAN		+ 11) * - ( 1-20-69 8:05 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
THE JOHNS HOPKINS HOSPITAL				BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				124 KENWOOD AVE.	
S. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
FEMALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2-1-31	37	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Packer		Glass Co.		Balto. Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
STEVEN LOWRY			BERTHA FERGER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
No					
17. INFORMANT			ADDRESS		
Mr. Paul E. Chapman			1004 Compton St.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			2 mos		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A)			5 min		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
1-20-69 - tracheotomy		Ca. lung		Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from Jan 19 19 69 to Jan 20 19 69, that (1) (we) last saw the deceased alive on Jan 20 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
J. S. ATKINSON				1/20/69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
J. S. ATKINSON				THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		1 24 69		Balto. National	
24D. LOCATION		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
Balto. Md.		JAN 27 1969		P. B. B. B. B.	
24G. FUNERAL DIRECTOR		24H. ADDRESS		24I. DATE	
078 '9 C. B. B.		P. B. B. B. B.		1-20-69	

Continued of the day 21/02

Substitution sulphuric + potassium 21/02

1-20-69 - 1-20-69 - 1-20-69

20/02

20/02

20/02

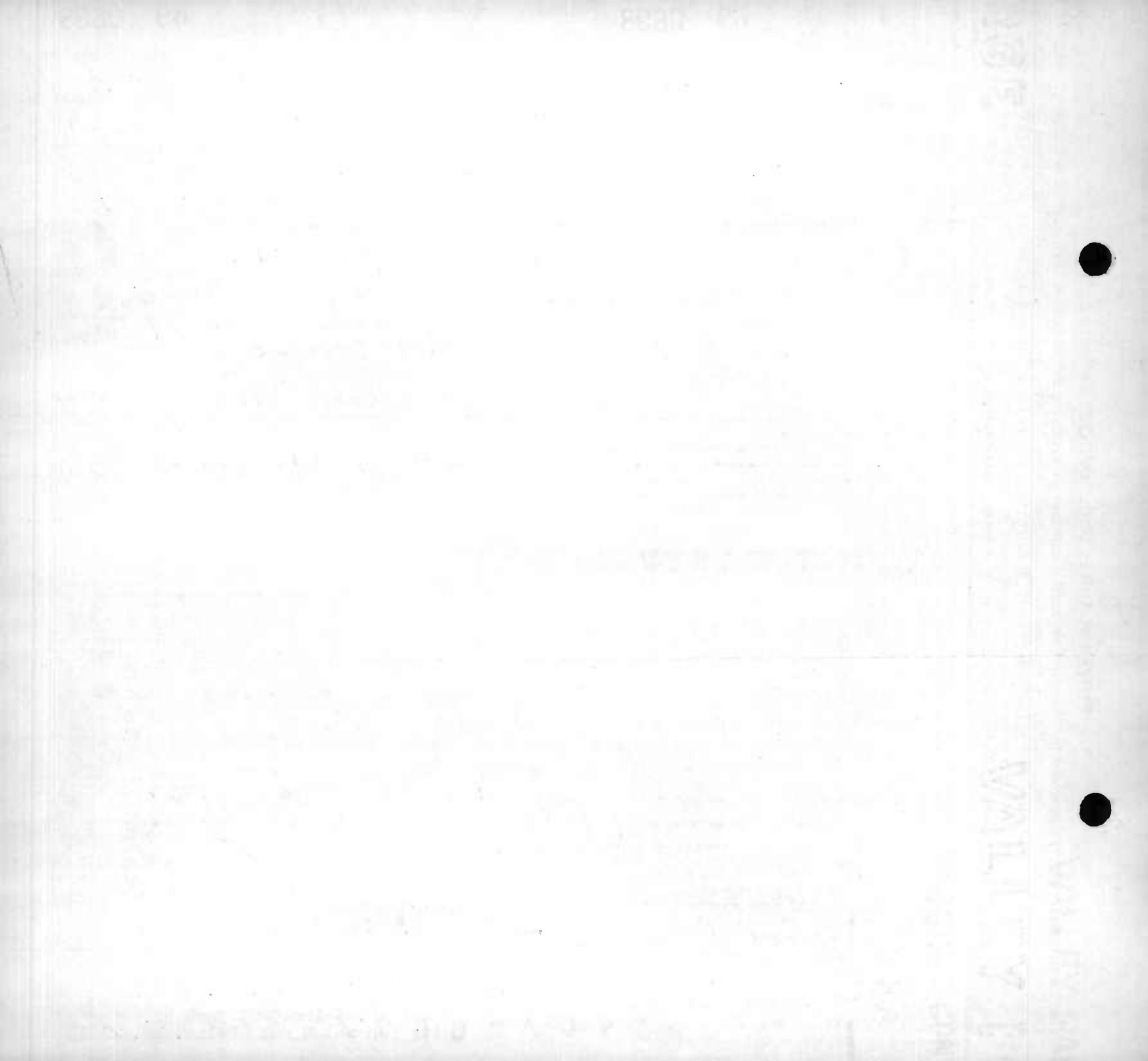
20/02



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		69 0898		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		69 0898	
1. NAME OF DECEASED (Type or Print) <b>ENIS MARIOTTI</b>				2. DATE AND HOUR OF DEATH <b>1/22/69 7:25 PM.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>8-31</b>					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>44 33rd + Calvary St. Union Memorial Hosp.</b>				C. CITY OR TOWN <b>MARYLAND</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <b>F</b> 6. RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>8/2/22/88</b>		9. AGE (In years last birthday) <b>60 yr</b>		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>ADULT</b>		11. BIRTHPLACE (State or foreign country) <b>ITALY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Mr. Oreste S. Mariotti</b>				14. MOTHER'S MAIDEN NAME <b>Mrs. Carolina Dall'Amico</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>215-10-9266-D</b>		17. INFORMANT <b>Mrs. Cora Carter</b>		ADDRESS <b>Same</b>	
18. <b>134X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cancer of breast</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>1 year</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>NONE</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NONE</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner) <b>NO</b>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NONE</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>NONE</b>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>1-22-69</b>				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1-22-69</b> to <b>1-22-69</b> and that (I) (we) last saw the deceased alive on <b>1-22-69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Dr. Francis Carmody</b>				23B. DATE SIGNED <b>1-22-69</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. Francis Carmody</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>1/25/1969</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>				25B. NAME OF REGISTRAR <b>Robert E. Tolson</b>		25C. FUNERAL DIRECTOR <b>Eugenia K. Seitz 5209 York Rd. Balto. Md. 21212</b>			



# FUNERAL DIRECTOR: IMPORTANT

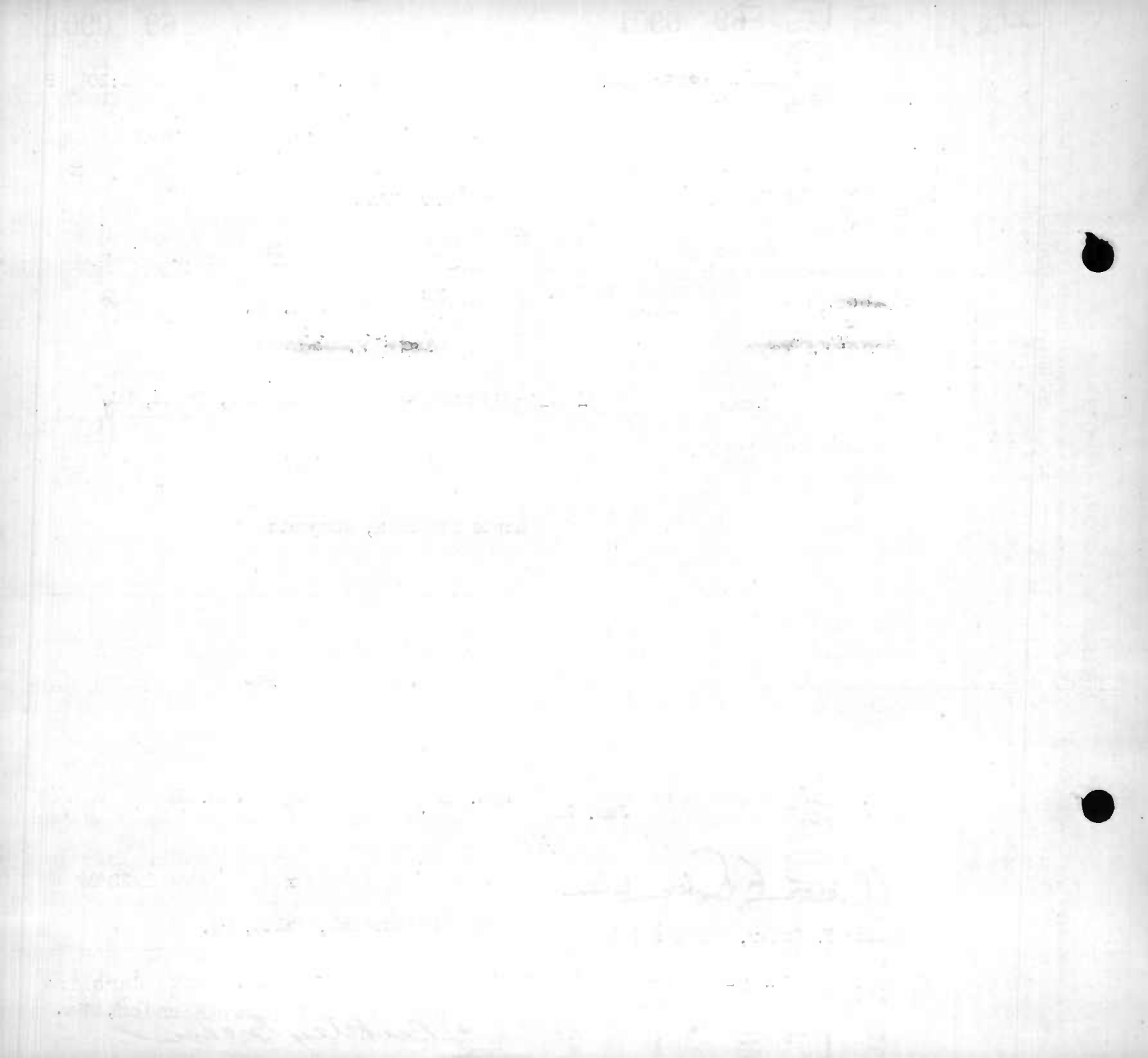
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed at final disposition is made.

RGB

## 69 0901 CERTIFICATE OF DEATH

REG. NO. 69 0901

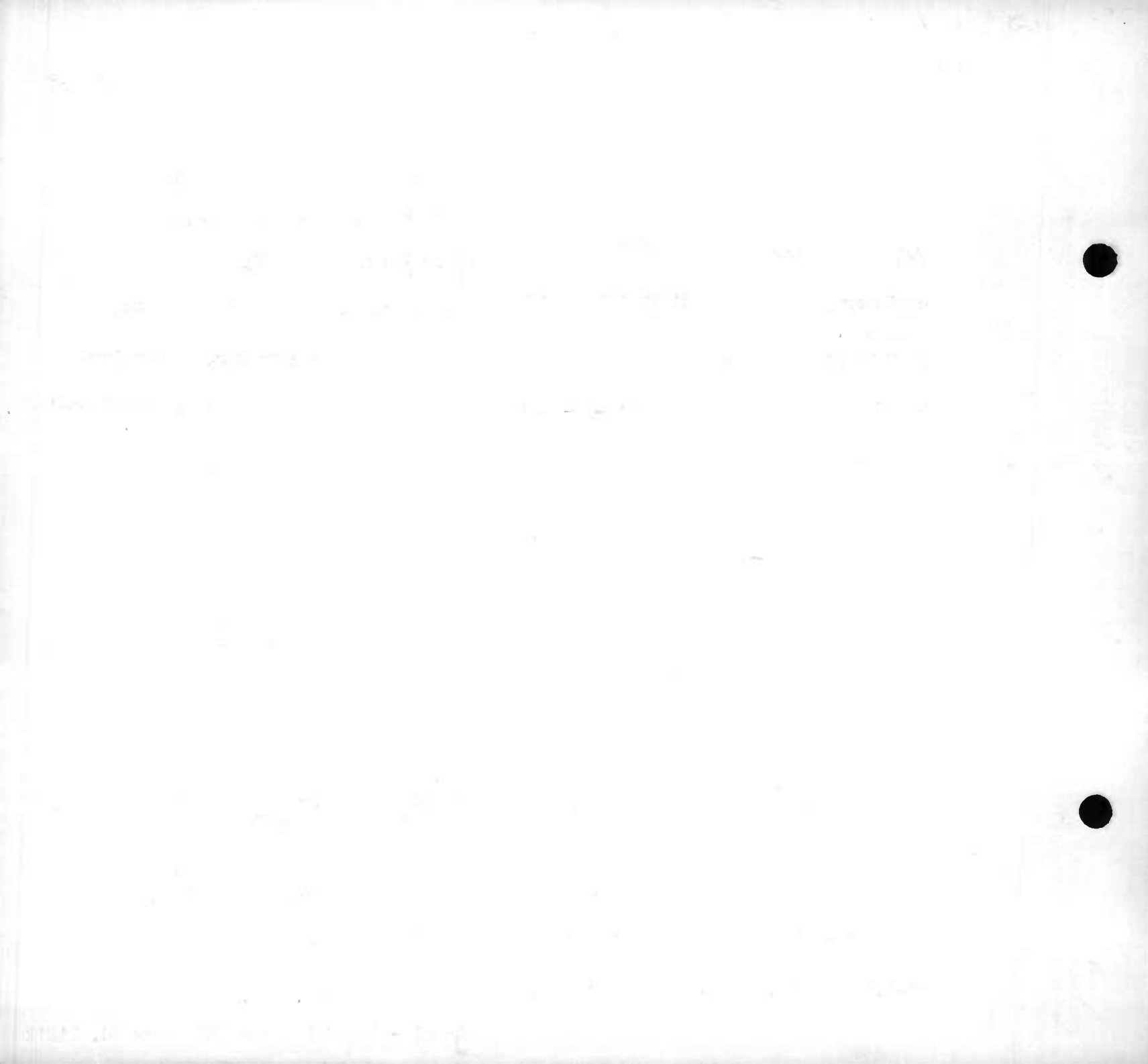
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>William Reece Mays</b>		2. DATE AND HOUR OF DEATH <b>Jan. 21, 1969</b> <b>1:20 P M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Va.</b> B. COUNTY <b>Loudoun County</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>US Public Health Service Hospital</b> <b>3100 Wyman Parkway</b>		C. CITY OR TOWN <b>Chantilly</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <b>RFD 241</b>					
5. SEX <b>male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/12/40</b>	9. AGE (In years last birthday) <b>28</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Construction Work</b>		11. BIRTHPLACE (State or foreign country) <b>Surry County, N. C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Reece T. Mays</b>			
14. MOTHER'S MAIDEN NAME <b>Elsie E. Mathis</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b> <b>None</b>			
16. SOCIAL SECURITY NO. <b>225-250-8384</b>		17. INFORMANT ADDRESS <b>Records- US PHS Hospital, Balto, Md.</b>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>Bronchopneumonia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Acute leukemia, suspected</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>?</b> <b>?</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan. 15</b> <b>19 69</b> to <b>Jan. 21</b> <b>19 69</b> , that (I) (we) lost saw the deceased alive on <b>Jan. 21</b> <b>19 69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Walter F. Oster</i> <b>WFO</b>		23B. DATE SIGNED <b>1/22/69</b>		23C. PHYSICIAN'S NAME (Type) <b>Walter F. Oster, Surgeon (R)</b>	
23D. ADDRESS <b>US PHS Hospital, Balto, Md.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal &amp; Burial</b>			
24B. DATE <b>1-22-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Pleasant Grove Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Clingman, North Carolina</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>JAN 27 1969</b>		25B. NAME OF REGISTRAR <i>Robert L. ...</i>		25C. FUNERAL DIRECTOR <i>Green</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				69 0902		REG. NO. 69 0902	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>PRESTON G. LEWIS</u>		2. DATE AND HOUR OF DEATH <u>1/22/69</u> <u>11 45 P.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>27-12</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEM. HOSP.</u> <u>44</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTO</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>6449 BLenheim RD.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/23/92</u>	9. AGE (In years last birthday) <u>76</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>engineer</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Boiler Inspector</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Meredith</u> <u>XXXXXXXXXX</u> <u>CENIS</u>			14. MOTHER'S MAIDEN NAME <u>MARY</u> <u>XXXXXXXXXX</u> <u>Douglas</u>		ADDRESS <u>MRS. ALICE LEWIS 6449 Blenheim RD.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>XXXXXXXXXX</u> <u>WWI</u>			16. SOCIAL SECURITY NO. <u>219-38-6371</u>		17. INFORMANT <u>MRS. ALICE LEWIS</u>		
18. <u>4-33-1</u> CAUSE OF DEATH				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cerebrovascular Thrombosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic Disease</u>			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Y.S.</u>							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>1/15</u> 19 <u>69</u> to <u>1/22</u> 19 <u>69</u> . that (1) (we) last saw the deceased alive on <u>1/22</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u> <u>MD</u>				23B. DATE SIGNED <u>1/22/69</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <u>ALLAN D. JENSEN, M.D.</u>				23D. ADDRESS <u>UNION MEM. HOSP.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>1/25/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 27 1969</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>Mitchell Wiedefeld Home 6500 York Rd. 21212</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 69 0904 CERTIFICATE OF DEATH

REG. NO.

69 0904

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ADAMS, Clarence Russell

2. DATE AND HOUR OF DEATH

1/22/1969

10:45 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Veterans Administration Hospital  
3900 Loch Raven Boulevard  
Baltimore, Maryland 21218

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

337 Ilchester Avenue

5. SEX

Male

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

3/21/96

9. AGE (In years last birthday)

72

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Pipe fitter

10B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel Co.

11. BIRTHPLACE (State or foreign country)

Shamokin, Pa.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry Adams

14. MOTHER'S MAIDEN NAME

Lillie Derr

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

5/28/18 - 5/27/19

16. SOCIAL SECURITY NO.

178005-0515

17. INFORMANT

VA Hospital Records

ADDRESS

3900 Loch Raven Boulevard, Balto., Md 21218

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE Respiratory insufficiency  
DUE TO, OR AS A CONSEQUENCE OF: Pulmonary edema,  
left; necrosis and fibrosis  
right lung

(B) DUE TO, OR AS A CONSEQUENCE OF: Lung malignancy, status post  
lobectomy and radiotherapy; myocardial

insufficiency months

greater

than

one

hour

greater

than 6

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

Tuberculosis, pulmonary

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 22nd 19 69 to January 22nd 19 69 that (I) (we) last saw the deceased alive on January 22nd 19 69 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.

23A. SIGNATURE

George W. Gaffney

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1/23/69

23C. PHYSICIAN'S NAME (Type)

GEORGE W. GAFFNEY, M.D.

23D. ADDRESS

3900 Loch Raven Boulevard  
Baltimore, Maryland 21218

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1/27/69

24C. NAME OF CEMETERY OR CREMATORY

Baltimore National

24D. LOCATION (City, town, or county)

Balto. Md.

25A. DATE RECEIVED BY HEALTH DEPT.

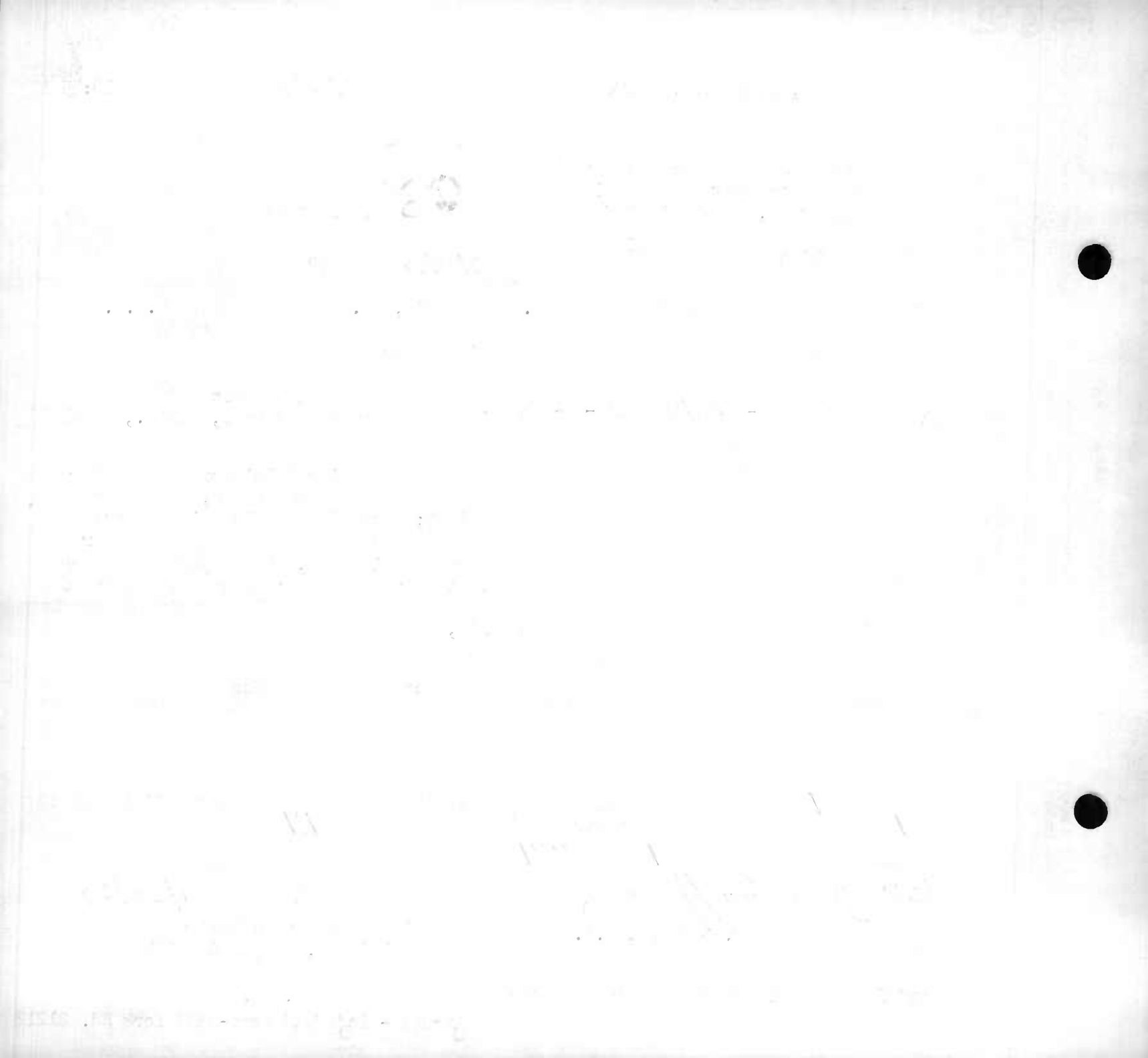
JAN 27 1969

25B. NAME OF REGISTRAR

George W. Gaffney

25C. FUNERAL DIRECTOR

Matchell-Wiedefeld Home-6500 York Rd. 21212





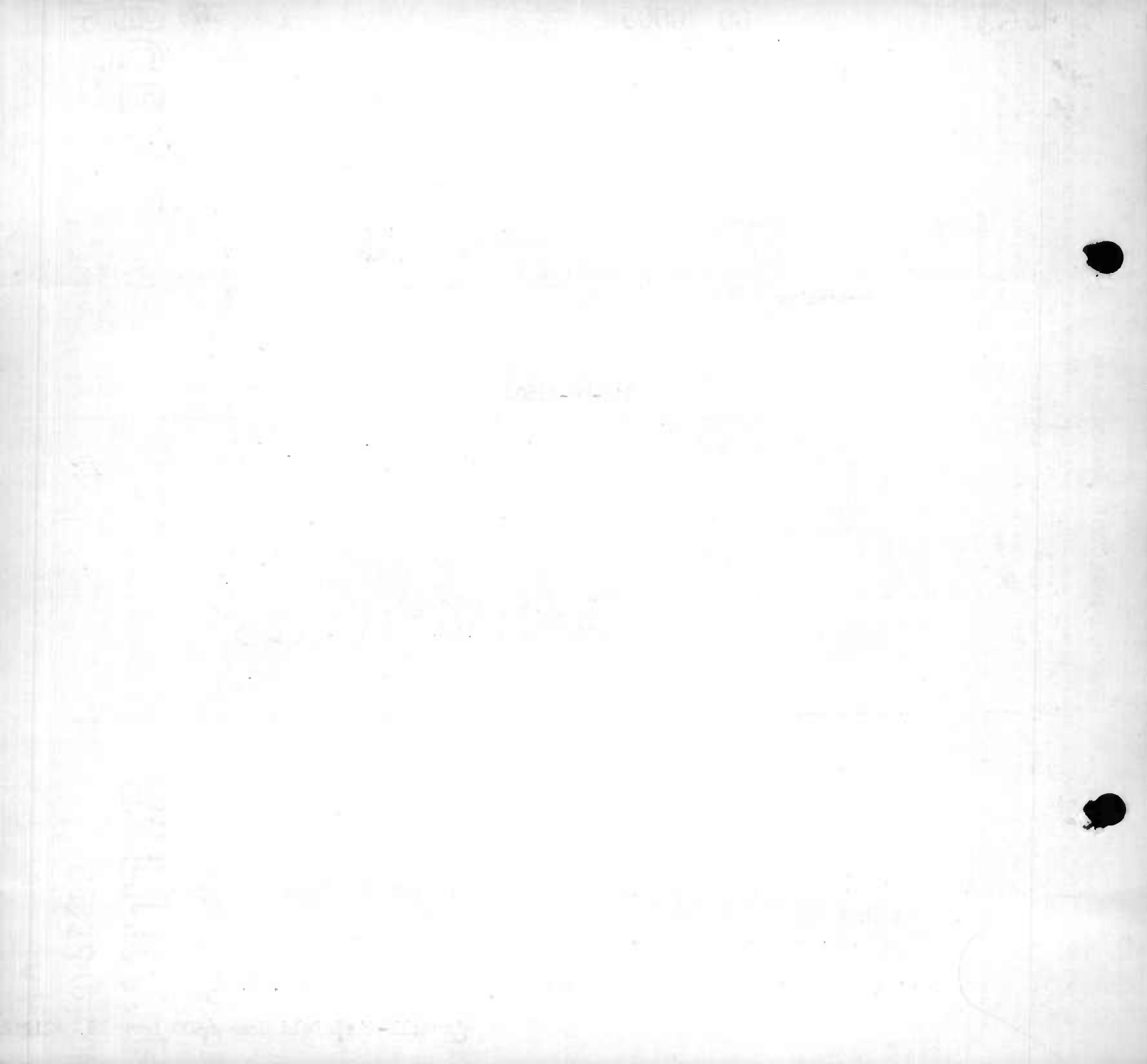
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## 69 0905 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. **69 0905**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MARY BROWN</b>		2. DATE AND HOUR OF DEATH <b>JAN 22, 1969 8<sup>30</sup> P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>48 Mayland Shulz Hosp</b>			A. STATE <b>Maryland</b> B. COUNTY <b>11-02</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>101 W Monument St</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1879 8-10-1886</b>		9. AGE (In years lost birthday) <b>89</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>homemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Charles A Brown</b>			14. MOTHER'S MAIDEN NAME <b>Mary C. Allen</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-45-8860J</b>	17. INFORMANT <b>Walter Small, 3845 Loch Raven Blvd,</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>PULMONARY ATLECTASIS</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>PLEURAL EFFUSION</b>		
			(B) DUE TO, OR AS A CONSEQUENCE OF: <b>+ CHOLECYSTITIS</b>		
			(C) <b>Chronic cholecystitis</b>		<b>1 year</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>PULMONARY EMBOLI BILATERAL; PORTAL CIRRHOSIS; ASCUD</b>					
19A. DATE OF OPERATION <b>12-5-68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cholecystitis, Chronic cholecystitis</b>		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>No</b>		21C. WHERE DID INJURY OCCUR? <b>No</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <b>No</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>No</b>	
22. I certify that (1) (this hospital) attended the deceased from <b>November 29, 1968</b> to <b>January 22, 1969</b> , that (1) (we) last saw the deceased alive on <b>January 22, 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>TERRAN M HIMELEFARB MD</b>				23B. DATE SIGNED <b>Jan 22, 1969</b>	
23C. PHYSICIAN'S NAME (Type) <b>TERRAN M HIMELEFARB MD</b>				23D. ADDRESS <b>Md Laurel Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>1/25/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cem.</b>	
				24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Galt, MD</b>		25C. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home</b>	
				ADDRESS <b>6500 York Rd. #21212</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 69 0903 CERTIFICATE OF DEATH

REG. NO. 69 0903

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Price Annie E. Trolinger</b>		2. DATE AND HOUR OF DEATH <b>1/25/1969</b>		7/10 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 218 Ridgewood Rd.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> 8. COUNTY <b>Balto. Co.</b> 53-00 C. CITY OR TOWN <b>Towson</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>919 Southerly Rd.</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/30/1871</b>	9. AGE (In years last birthday) <b>97</b>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington Co. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Price</b>			14. MOTHER'S MAIDEN NAME <b>Martha Crow</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>W.P. Trolinger</b>			
				ADDRESS <b>4401 Roland Ave</b>			
18. <b>440.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH <b>Arteriosclerosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1956</b> 19 to <b>January 25 1969</b> that (I) (we) last saw the deceased alive on <b>January 23 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (they) (did not) view the body after death.							
23A. SIGNATURE <b>William G. Helfrich</b>				23B. DATE SIGNED <b>1-25-69</b>			
23C. PHYSICIAN'S NAME (Type) <b>Dr. William G. Helfrich</b>				23D. ADDRESS <b>5006 Roland Ave Balto, Md</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/29/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oakwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Pulaski, Va.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Trolinger</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Mitchell Wiedefeld Home 6500 York R</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0906		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		69 0906	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		WILLIE GREEN		1-25-69 9:50 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND		BALTIMORE CITY	
33 THE JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		2111 MOUNT HOLLY STREET		21216	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
MALE	NEGRO	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2-12-09	59	11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laborer		Dunbar Co.		SOLMA ALA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
William Green		Dunbar		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no				Dunbar 2111 Mt Holly St	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
I		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Arteriosclerotic myocardial disease 1 year	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2-1-69				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
<input type="checkbox"/>					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1-16-69 to 1-25-69					
that (I) (we) last saw the deceased alive on 1-25-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
J.S. ATKINSON, MD		1-25-69			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
J.S. ATKINSON		THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1/20/69		Mt Calvary	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 27 1969		Robert E. Stokely		Dunbar 2111 Mt Holly St	

Orange Blossom  
Honey

1-22-24

1-22-24

1-22-24

1-22-24

1-22-24

# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 0907	
1. NAME OF DECEASED (Type or Print)		FLORENCE SOUTHERLAND		2. DATE AND HOUR OF DEATH <del>1-26-69</del> 1-26-69 1:30 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL		MARYLAND BALTIMORE CITY 7-02		C. CITY OR TOWN D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input checked="" type="checkbox"/> X NO <input type="checkbox"/>	
		E. STREET AND NUMBER		2530 E. EAGER STREET 21205	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
FEMALE	NEGRO	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	6-30-85	83	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Homemaker		at home		VA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
HARRISON CHARLES HOLMAN		ELLEN YELVERTON		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				Evelyn Quomony 2530 E. EAGER St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, oshteno, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Chronic renal disease with uremia 2 years	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from 1-2 1969 to 1-26 1969					
that (1) (we) lost saw the deceased alive on 1-25 1969 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
J.S. ATKINSON				1-26-69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
J.S. ATKINSON				THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		1/27/69		Carver Mem. Pk	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
Shamater Va.		JAN 27 1969		J. S. Atkinson	
24G. FUNERAL DIRECTOR		24H. ADDRESS		24I. DATE	
J. S. Atkinson		2387 Gibson St		1-26-69	

Account of the ...  
... ..

1-24-04

1-24-04



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
69 0908 CERTIFICATE OF DEATH

REG. NO. 69 0908

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

David R. Riddick

2. DATE AND HOUR OF DEATH

1-24-69

1:45 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)Provident Hospital  
1514 Division Street  
Baltimore, Maryland 212174. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN  
Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1427 Edmondson Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

? April - 89

9. AGE (In years  
last birthday)

79

11. Under 1 Yr.  
Months: Days:If Under 24 Hrs.  
Hours: Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

?

11. BIRTHPLACE (State or foreign country)

Norfolk Va

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Joseph Riddick

14. MOTHER'S MAIDEN NAME

Mary

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mr. Royal David (Son)

ADDRESS

same

18.

433.91

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cerebral thrombosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-18-69 to 1-24-69, that (I) (we) last saw the deceased alive on 1-24-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Virginia Y. Fausto, M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

1-24-69

23C. PHYSICIAN'S  
NAME (Type)

Dr. V. Fausto

23D. ADDRESS

Provident Hospital

1514 Division Street - Baltimore, Maryland

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

1/24/69

24C. NAME OF CEMETERY or CREMATORY

Mt Auburn

24D. LOCATION

Baltimore

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 27 1969

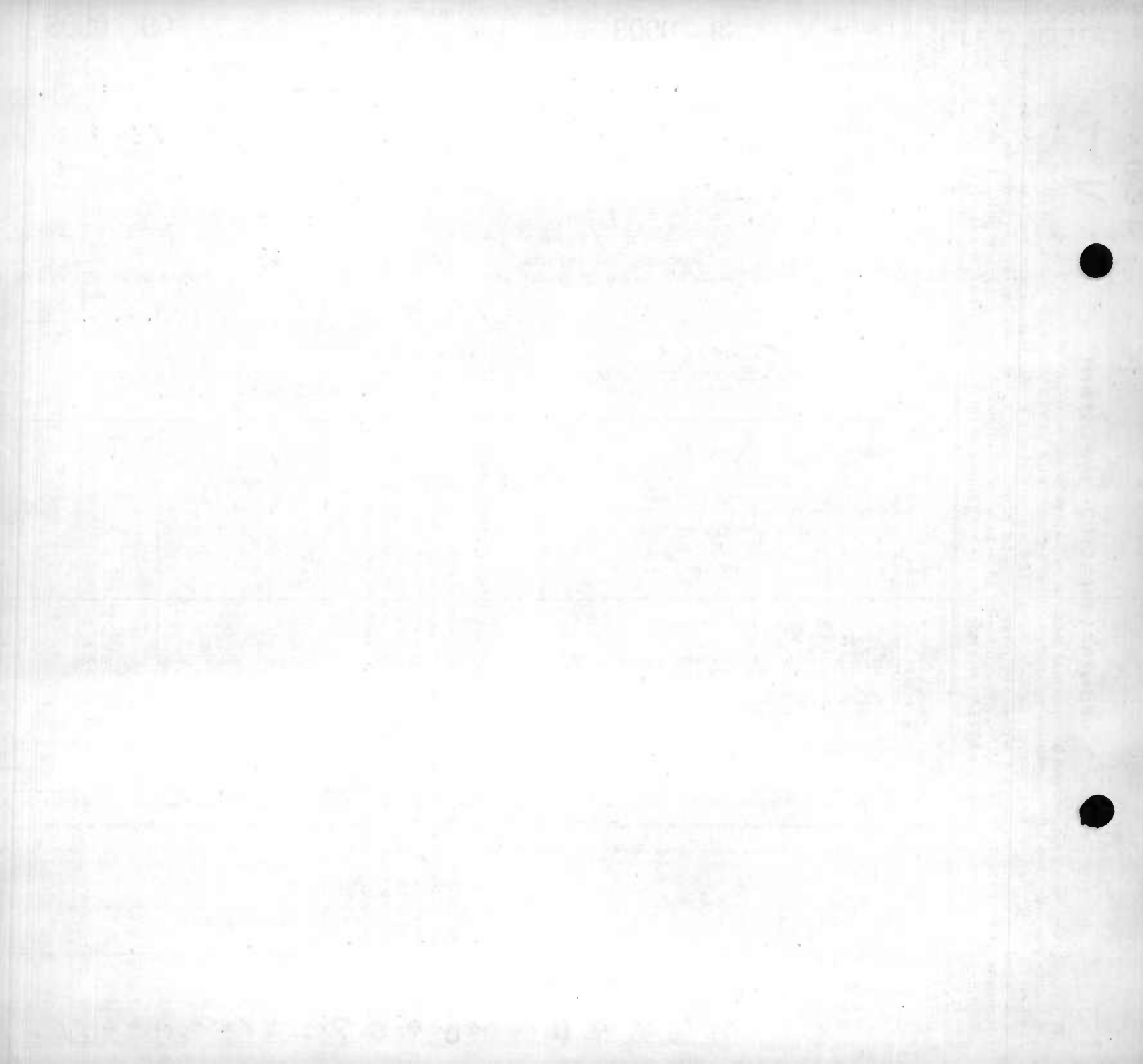
25B. NAME OF REGISTRAR

R. J. J. J. J.

25C. FUNERAL DIRECTOR

R. J. J. J. J.

ADDRESS



P-600

69 0909 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 0909

REG. NO.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) CLARENCE S. PERRY		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year January 24, 1969		Hour 9:05 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION PROVIDENT HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year January 24, 1969		Hour 9:05 A. M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 16-08	
6. SEX Male	7. RACE Negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 12/1/03	10. AGE (In years lost birthday) 65	11. BIRTHPLACE (State or foreign country) NORFOLK VA		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME SHAKESPEARE PERRY	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FURNITURE REFINISHER		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Mary Alice Dowdy			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 231-10-2264		18. INFORMANT Mary A Edwards		ADDRESS 3703 COLTON DR	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Carcinoma of Lung		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/24/69			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/28/69		24C. NAME of CEMETERY or CREMATORY Calvary		24D. LOCATION (City, town, or county) (State) NORFOLK VA	
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1969		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR Margaret P. Jones		ADDRESS 3877 GLENDALE ST Ft. Belvoir, F.H. Portsmouth VA	

Paul M. Kelly

FUNERAL DIRECTOR: IMPORTANT

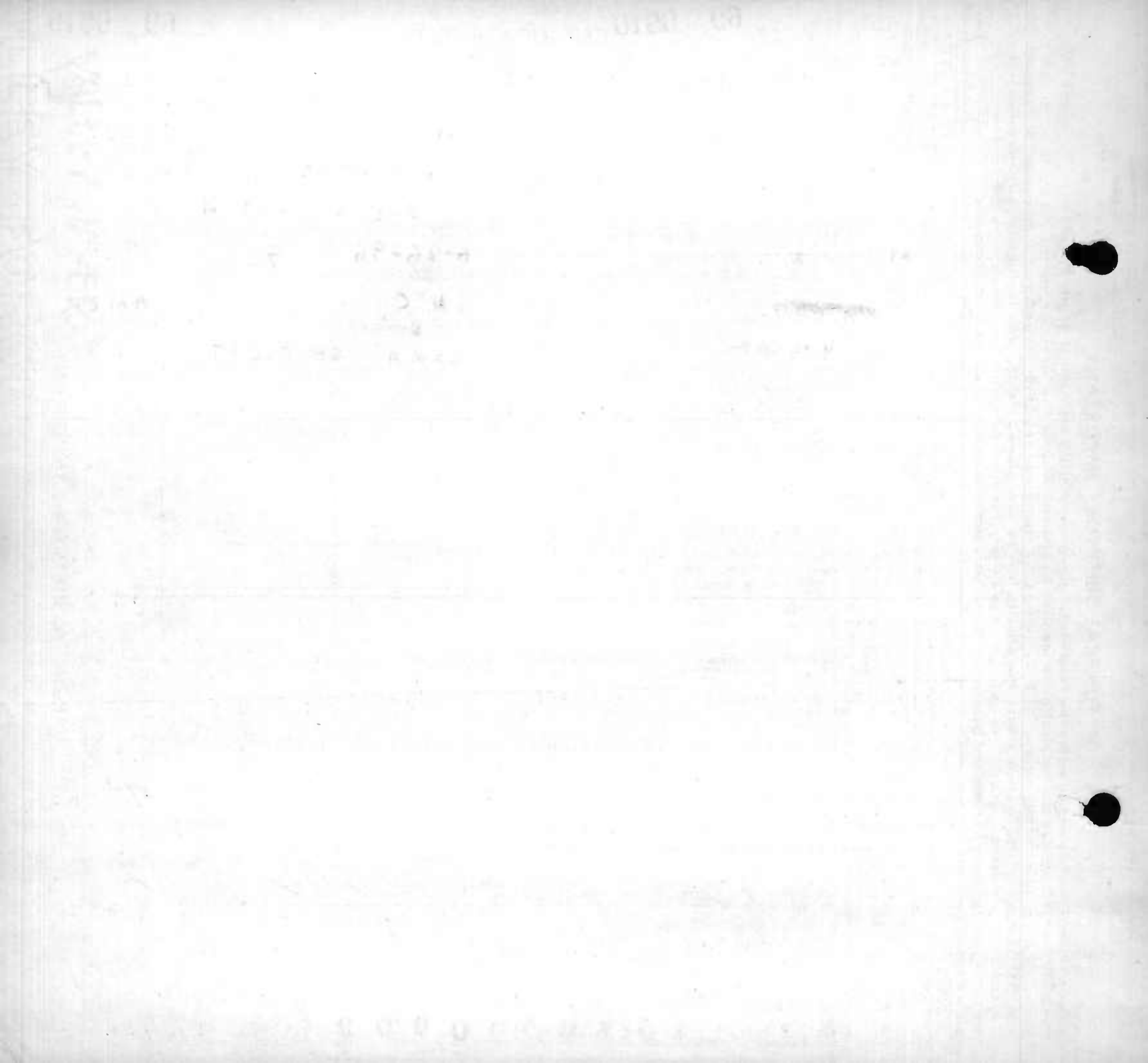
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0910

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 0910

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		CHESHIRE HOLLARS		1-24-69 2:50 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
35 CHURCH HOME & HOSPITAL				Md 3-01	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
M		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
6-26-96		72		NIGHT WATCHMAN	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
N. CAROLINA		AMER		ANDY HOLLARS	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
SARA SHIFLETT		Yes W.W.I		240-30-4596A	
17. INFORMANT		18. CAUSE OF DEATH		19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	
Epie Hollars - 208 S. Eden St.				(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	
		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Upper GI bleeding undet.	
		(B) DUE TO, OR AS A CONSEQUENCE OF:		Hypertensive Heart Disease year.	
		(C) _____			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPRDX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1-23 1969 to 1-24 1969, that (I) (we) last saw the deceased alive on 1-24 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
J. C. MARIANO					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
J.C. MARIANO				CHURCH HOME & HOSPITAL BALTO. Md. 31	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		1/29/69		Baltimore National Cem.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
Baltimore, Md.		JAN 27 1969		John J. Connel, Jr., Sec. 901 Hollins St. Balto. Md.	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 0911

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>WILLIE MATHIS HALL</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>1 23 69 8:50 p M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>D.O.A. 3rd floor</b> <b>3302 Auchentoroly Terrace</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 23, 1969 8:50 p M.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>13-04</b>			
6. SEX <b>Male</b>	7. RACE <b>Colored</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH <b>8/22/18</b>	10. AGE (In years last birthday) <b>50</b>	E. STREET AND NUMBER <b>3302 Auchentoroly Terrace</b>	
11. BIRTHPLACE (State or foreign country) <b>Me</b>		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>L</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
		15. MOTHER'S MAIDEN NAME <b>Bertha Lewis</b> 18. INFORMANT <b>Ellenath Funeral Home</b> ADDRESS	
19. <b>412.41250.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Diabetes mellitus</b>			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1/24/69</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>	24B. DATE <b>1/24/69</b>	24C. NAME OF CEMETERY or CREMATORY <b>Wake Forest</b>	24D. LOCATION (City, town, or county) (State) <b>North Carolina</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>	25B. NAME OF REGISTRAR <b>02-02-70000</b>	25C. FUNERAL DIRECTOR <b>32 Brown</b>	ADDRESS <b>108 W. 1st St. Montgomery - 4</b>



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THE HONORABLE CHIEF OF POLICE

NEW YORK

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NEW YORK

NEW YORK

NEW YORK



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0912

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

69 0912

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Lee Miller, Jr.

2. DATE AND HOUR OF DEATH

1-14-69 11<sup>00</sup> P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Md.

23.01

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

1016 Leadenhall St.

5. SEX

M

6. RACE

N

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

9/2/02

9. AGE (In years last birthday)

65

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

2

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Genlte L. Miller, Sr.

14. MOTHER'S MAIDEN NAME

Phoebe Lemon

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Miller Miller 1016 Leadenhall St

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE Subarachnoid Hemorrhage  
DUE TO, OR AS A CONSEQUENCE OF:

(B) Hypertensive Cerebrovascular Accident  
DUE TO, OR AS A CONSEQUENCE OF:

(C) HA SCVD Disease

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (H) (this hospital) attended the deceased from 1-14 1969 to 1-14 1969 that (I) (we) lost saw the deceased alive on 1-14 1969 and that (in my) (four) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Stanley R. Weimer, M.D.

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1-14-69

23C. PHYSICIAN'S NAME (Type)

Stanley R. Weimer M.D.

DEGREE

23D. ADDRESS

South Baltimore General Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Remove 1/17/69 Manning

25A. DATE RECEIVED BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JAN 27 1969

Robert E. Thompson

108 W. 1st St. Baltimore, Md.

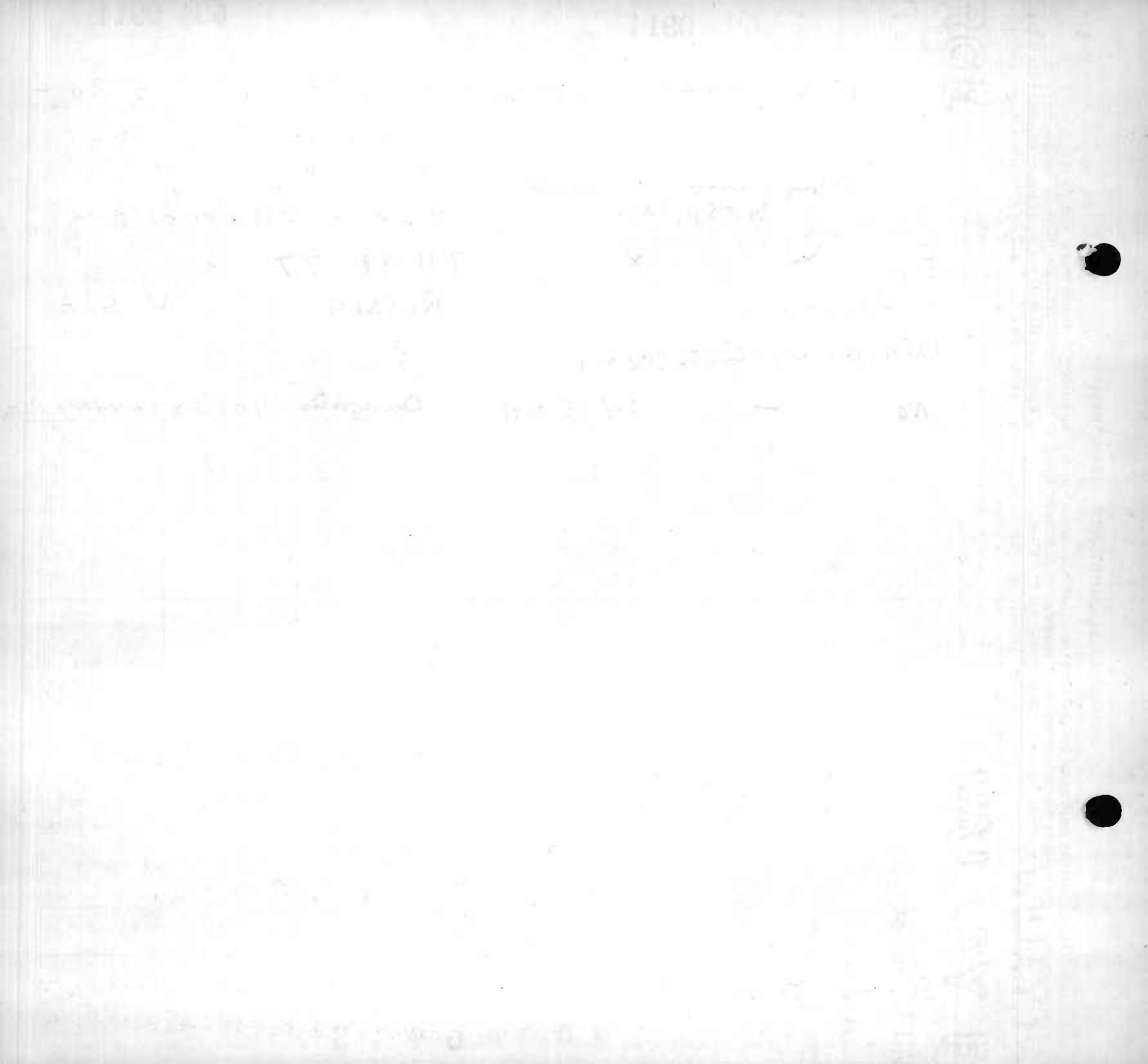
21

George Washington University  
Library  
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VS 150-REV. 1/1/68



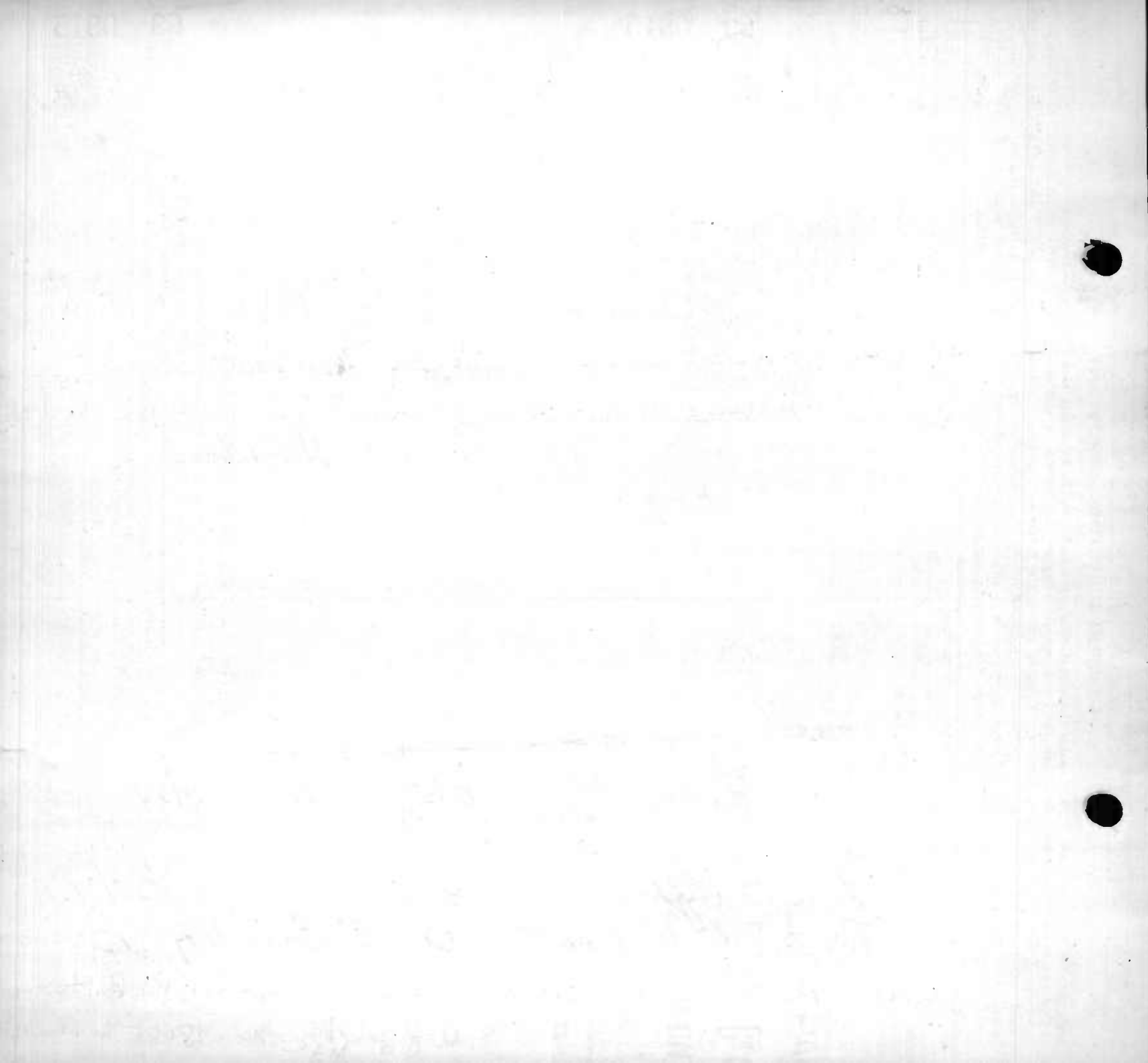
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0915 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 69 0915

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Albert John Schultz		Jan 24 1969 1:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION Church Home Hosp.				A. STATE Md.	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY 1-05	
5. SEX Male		6. RACE White		C. CITY OR TOWN Balto.	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 21-1905		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 63			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foremanship carp		10B. KIND OF BUSINESS OR INDUSTRY Shipping		11. BIRTHPLACE (State or foreign country) Balto. Md.	
13. FATHER'S NAME John Schultz		14. MOTHER'S MAIDEN NAME Anna Zachon		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes (DND) Dec. 21-20 217-035856		16. SOCIAL SECURITY NO. 217-035856		17. INFORMANT Emma E. Schultz (wife) Chestons	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Rheumatic Heart disease		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 40 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/15 19 67 to 1/24 19 68, that (I) (we) last saw the deceased alive on 11/29 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Irvin B. Kaplan				23B. DATE SIGNED 1/27/69	
23C. PHYSICIAN'S NAME (Type) Irvin B. Kaplan MD				23D. ADDRESS 129 S. Broadway Balto 71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-27-69		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem	
24D. LOCATION (City, town, or county) (State) Balto. Md.		24E. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem		24F. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1969		25B. NAME OF REGISTRAR Robert E. Starnes		25C. FUNERAL DIRECTOR J. D. Spivey Inc. 1800 E. Lombards	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## Baltimore City Health Department CERTIFICATE OF DEATH

REG. NO.

69 0916

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Donald Stephen Krugulka

2. DATE AND HOUR OF DEATH

JAN. 23 1969 1 50 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Md.

Baltimore Co

C. CITY OR TOWN

Clansdowne RE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

3115 Ryerson Circle

5. SEX

M

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

OCT. 11, 1922

9. AGE (In years last birthday)

46

10. Under 1 Yr. Months Days

11. Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

CLERK

10B. KIND OF BUSINESS OR INDUSTRY

Schenuit Industries

11. BIRTHPLACE (State or foreign country)

VERMONT

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Stephen Krugulka

14. MOTHER'S MAIDEN NAME

Nettie Liberty

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

W W II

16. SOCIAL SECURITY NO.

008-14-5534

17. INFORMANT

PATIENT'S CHART

ADDRESS

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Progressive Lymphosarcoma

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

7 years

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from DEC 26 1968 to JAN 23 1969 that (I) (we) last saw the deceased alive on JAN. 22 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Frederick E. Knowles, MD

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1/23/69

23C. PHYSICIAN'S NAME (Type)

FREDERICK E. KNOWLES, M.D.

23D. ADDRESS

University Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

Cremation

24B. DATE

1-25-1969

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Crematory

24D. LOCATION

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JAN 27 1969

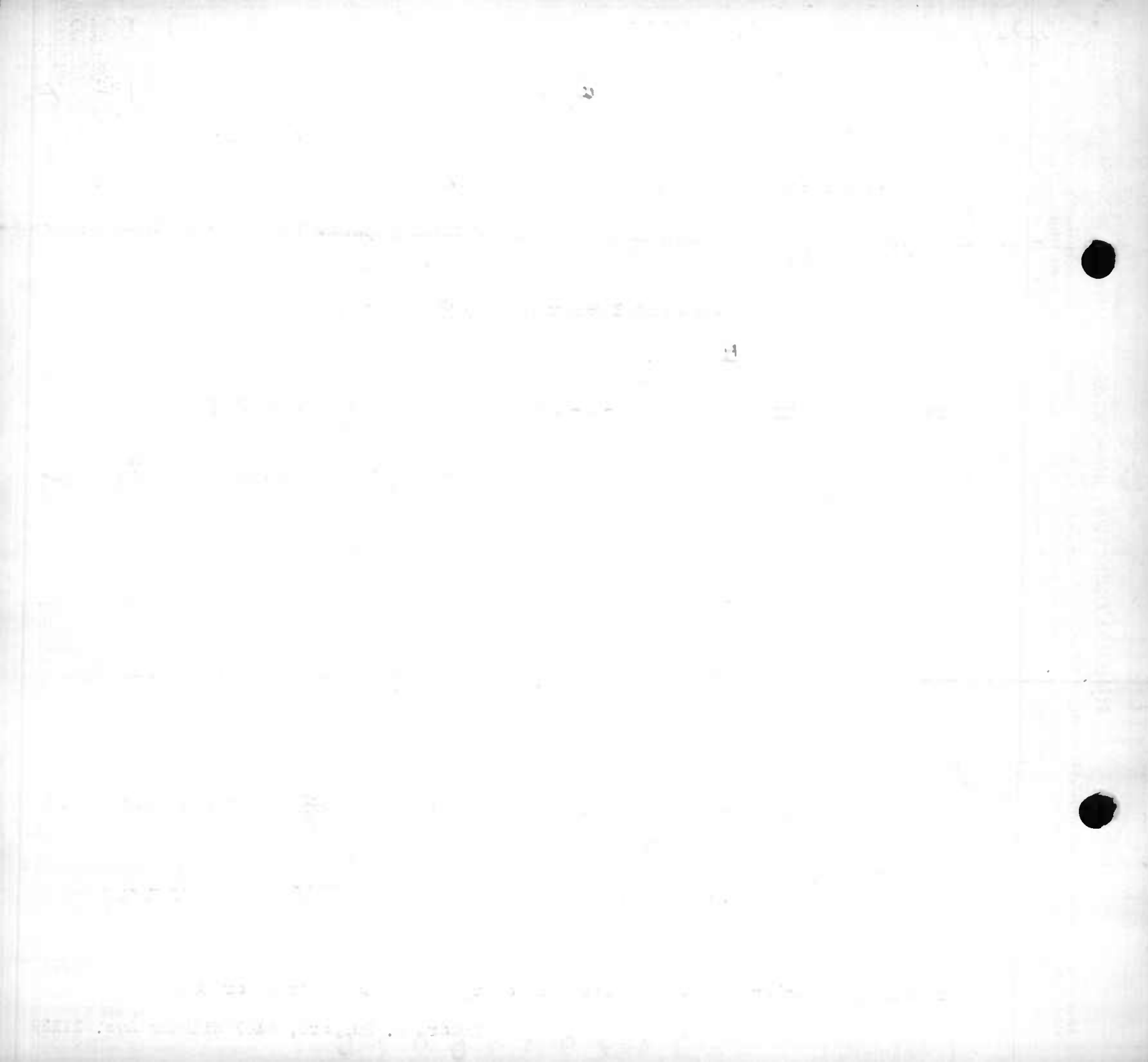
25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

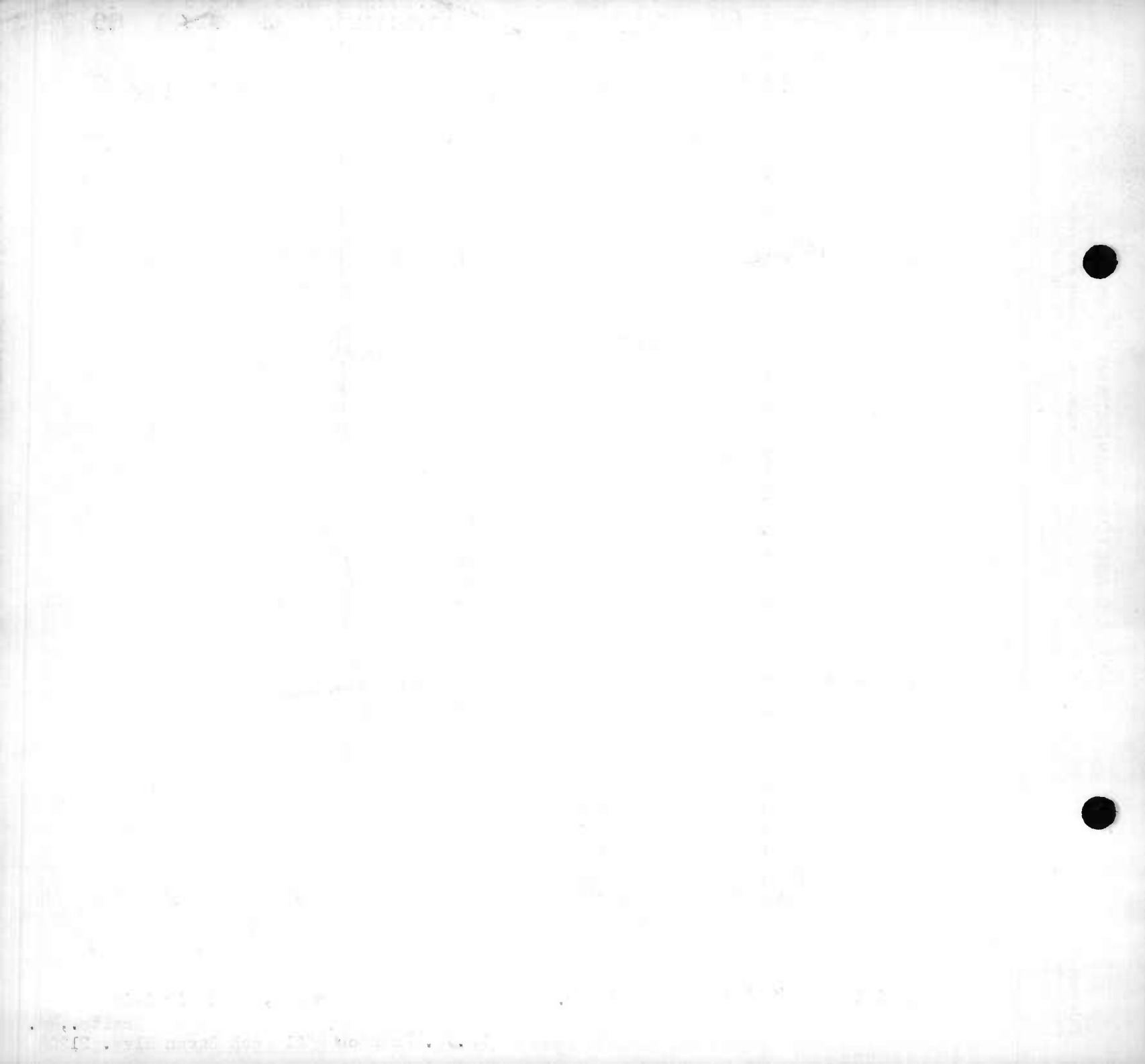
Howard H. Hubbard, 4107 Wilkens Ave. 21229

ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>69 0918</b>
K-200 <b>69 0918</b>		<b>CERTIFICATE OF DEATH</b>		
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Philemon Wall Keech</b>		2. DATE AND HOUR OF DEATH <b>JAN 22 1969 845P M.</b>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>26-12</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 Baltimore City Hospitals</b> <b>4940 Eastern Ave.</b> <b>Baltimore, Maryland #21224</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>- 6 -</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland, Baltimore</b>
13. FATHER'S NAME <b>Philemon Keech</b>		14. MOTHER'S MAIDEN NAME <b>Bessie Rea</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>BCH Records: 4940 Eastern Ave</b> <b>Baltimore, Maryland #21224</b>
18. <b>343.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Paralytic Ileus</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 mo</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebral Palsy &amp; paraplegia</b>		<b>66 yrs.</b>
		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Congenital idiosyncrasy</b>		<b>66 yrs.</b>
		(C) <b>Ascites</b>		<b>4 mo.</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <b>2/</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <b>we</b> (this hospital) attended the deceased from <b>9-19</b> 19 <b>50</b> to <b>JAN 22</b> 19 <b>69</b> , that <b>we</b> last saw the deceased alive on <b>JAN 22</b> 19 <b>69</b> and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>we</b> (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Rolf H. Bessin MD</b>		23B. DATE SIGNED <b>JAN 22 1969</b>		23C. PHYSICIAN'S NAME (Type) <b>ROLF H. BESSIN MD</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/25/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>		25B. NAME OF REGISTRAR <b>Regis. E. G. G. G.</b>		25C. FUNERAL DIRECTOR <b>190 Edmonson Ave.</b> <b>Catonsville, Md. 21228</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		24E. ADDRESS <b>BCH 4940 Eastern Ave.</b> <b>Baltimore, Maryland #21224</b>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>ELIZABETH ARMSTRONG</b>				2. DATE AND HOUR OF DEATH <b>1/23/69 1:40 P.M.</b>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>House in Lines - Belair Rd. 90 5837 Belair Rd.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>DUNDALK</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>1813 SNYDER AVE</b>							
5. SEX <b>Female</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 24, 1876</b>		9. AGE (In years lost birthday) <b>92</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			
13. FATHER'S NAME <b>FREDERICK BAUER</b>				14. MOTHER'S MAIDEN NAME <b>LENA EGGERT</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>213-36-3643</b>				17. INFORMANT <b>MRS MARGARET CARTER - 1813 SNYDER AVE</b>			
18. <b>485X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Dissecta multilobata Decubiti Pernix Perforans Emboli</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial Infarction</b> (B) <b>Post - Bronchopneumonia</b> (C) <b>Dissecta multilobata Decubiti Pernix Perforans Emboli</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>8 days</b> <b>years</b>			
19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <b>No</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>9/7/1967</b> to <b>1/23/1969</b> . that (I) ( <del>we</del> ) last saw the deceased alive on <b>1/22/1969</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.											
23A. SIGNATURE <b>Albert B Bradley</b>								23B. DATE SIGNED <b>1/23/69</b>		23C. PHYSICIAN'S NAME (Type) <b>ALBERT B. BRADLEY M.D.</b>	
23D. ADDRESS <b>4900 BELAIR ROAD</b>								24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1/27/69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>OAK LAWN</b>								24D. LOCATION (City, town, or county) (State) <b>COLGATE MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>	
25B. NAME OF REGISTRAR <b>Robert E. Long</b>								25C. FUNERAL DIRECTOR <b>WILLIAM FUNERAL HOME - DUNDALK MD</b>		25D. ADDRESS	

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69 0920 BALTIMORE CITY HEALTH DEPARTMENT

69 0920

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CLARENCE G. RHYNER

2. DATE OF DEATH Known ☒ Estimated ☐ Month Day Year Hour  
1 25 69 10:25 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

3. DATE PRONOUNCED DEAD Month Day Year Hour  
January 25, 1969 10:25 a.m.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Maryland

13-07

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

9/7/1896

10. AGE (In years last birthday)

72

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

827 Union Ave.

11. BIRTHPLACE (State or foreign country)

N. Carolina

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Glenny L. Rhyner

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Sheet Metal Work.

14B. KIND OF BUSINESS OR INDUSTRY

Martin's

15. MOTHER'S MAIDEN NAME

Elizabeth Rowell

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service)

Yes

WW I

17. SOCIAL SECURITY NO.

220-22-3772

18. INFORMANT

ADDRESS

Mrs. Mamie P. Rhyner-827 Union Ave.

19. 412.4

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

22E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/25/69

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1/28/69

24C. NAME OF CEMETERY or CREMATORY

Moreland Mem. Park

24D. LOCATION (City, town, or county)

Baltimore,

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 27 1969

25B. NAME OF REGISTRAR

Robert E. Fairbairn

25C. FUNERAL DIRECTOR

Austin E. Donovan-3818 Roland Ave.

1980-10

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 69 0921 CERTIFICATE OF DEATH

REG. NO.

69 0921

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <div style="text-align: center;">Rachel V. Burgan</div>		2. DATE AND HOUR OF DEATH Jan. 23, 1969 <span style="float: right;">5 P. M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="float: right;">Maryland</span> B. COUNTY <span style="float: right;">27-12</span>		
FULL NAME OF HOSPITAL OR INSTITUTION <div style="text-align: center;">5743 Edmondson Avenue Baltimore, Md.</div>			C. CITY OR TOWN <span style="float: right;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
5. SEX <span style="float: right;">Female</span>			6. RACE <span style="float: right;">White</span>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="float: right;">Homemaker</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="float: right;">---</span>		8. DATE OF BIRTH <span style="float: right;">Nov. 29, 1879</span>	
11. BIRTHPLACE (State or foreign country) <span style="float: right;">Baltimore, Md.</span>		12. CITIZEN OF WHAT COUNTRY? <span style="float: right;">USA</span>		9. AGE (In years last birthday) <span style="float: right;">89</span>	
13. FATHER'S NAME <span style="float: right;">Joseph H. Wilson</span>			14. MOTHER'S MAIDEN NAME <span style="float: right;">? Canapp</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="float: right;">No</span>		16. SOCIAL SECURITY NO. <span style="float: right;">---</span>		17. INFORMANT <span style="float: right;">James D. Burgan (Son) Same</span>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <span style="float: right;">431.9 I Hemorrhage Esophagus</span>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="float: right;">1 day</span>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <span style="float: right;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) lost saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date _____ and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="float: right;">William Goodman</span>				23B. DATE SIGNED <span style="float: right;">25 Jan 69</span>	
23C. PHYSICIAN'S NAME (Type) <span style="float: right;">William Goodman</span>				23D. ADDRESS <span style="float: right;">1334 Sulphur Spring Road</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="float: right;">Burial</span>		24B. DATE <span style="float: right;">1/27/1969</span>		24C. NAME OF CEMETERY or CREMATORY <span style="float: right;">Woodlawn Cemetery</span>	
24D. LOCATION (City, town, or county) (State) <span style="float: right;">Baltimore, Md.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="float: right;">JAN 27 1969</span>			
25B. NAME OF REGISTRAR <span style="float: right;">Eugenia K. Seitz</span>		25C. FUNERAL DIRECTOR <span style="float: right;">Seitz Funeral Home Balto. Md. 21212</span>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 0922				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 0922			
1. NAME OF DECEASED (Type or Print) SPARKS, MRS ANNABELLE.				2. DATE AND HOUR OF DEATH JAN. 23. 1969 9.12 A.M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE A.C. 52-00							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME & HOSPITAL BALTIMORE. MD 21231.				C. CITY OR TOWN BALTIMORE.				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 9617 NINTH AVENUE											
5. SEX FEMALE		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9.15. 06		9. AGE (In years last birthday) 62		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY -				11. BIRTHPLACE (State or foreign country) MD. Graysonville		12. CITIZEN OF WHAT COUNTRY? AMERICAN.	
13. FATHER'S NAME THOMAS LINCH				14. MOTHER'S MAIDEN NAME MARY HORNEY.							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO.				16. SOCIAL SECURITY NO. 219-07-3900		17. INFORMANT James Sparks 9617 9th Avenue 21234				ADDRESS	
18. 230.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Retrosacids Injuries - 2 days (B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes mellitus - years (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 11-15-1969 to 1-23-1969. that (I) (we) last saw the deceased alive on 1-23-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE J. Mier Jr. M.D. 23C. PHYSICIAN'S NAME (Type) JOSE MIER JR. M.D.				23B. DATE SIGNED 1-23-69		23D. ADDRESS 100 N. BROADWAY BALT. MD. 21231					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-27-1969		24C. NAME OF CEMETERY or CREMATORY Baltimore Nat'l Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md.					
25A. DATE REC'D BY HEALTH DEPT. JAN 28 1969		25B. NAME OF REGISTRAR J. Mier Jr.		25C. FUNERAL DIRECTOR J. Mier Jr.		25D. ADDRESS 7400 Park Rd.					



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 0923

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>CHESTER G. MAIZE</b> <del>CHESTER MAICE</del>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>January 23, 1969</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION ADDRESS OR LOCATION <b>South Baltimore General Hospital</b> <b>1-30-69 (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 23, 1969 7:00 A.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>25-05</b>	
9. DATE OF BIRTH <b>Oct 13, 1909</b>		10. AGE (In years last birthday) <b>59</b>	
11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.	
13. FATHER'S NAME <b>Jack Maize</b>		15. MOTHER'S MAIDEN NAME <b>Myrtle Griffin</b>	
19. <b>486 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Bilateral pneumonitis</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Same</b>	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> <b>(Partial)</b>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) <b>(Partial) Yes.</b>	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		DATE SIGNED <b>January 23, 1969</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/27/69</b>	
24C. NAME of CEMETERY or CREMATORY <b>Cedar Hill Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Ritchie Hwy AA Co Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairburn</b>	
25C. FUNERAL DIRECTOR <b>Mc Lully F.H. 237</b>		ADDRESS <b>21225</b>	

V.S. 153

1-30-69

M.H.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## 69 0924 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 69 0924

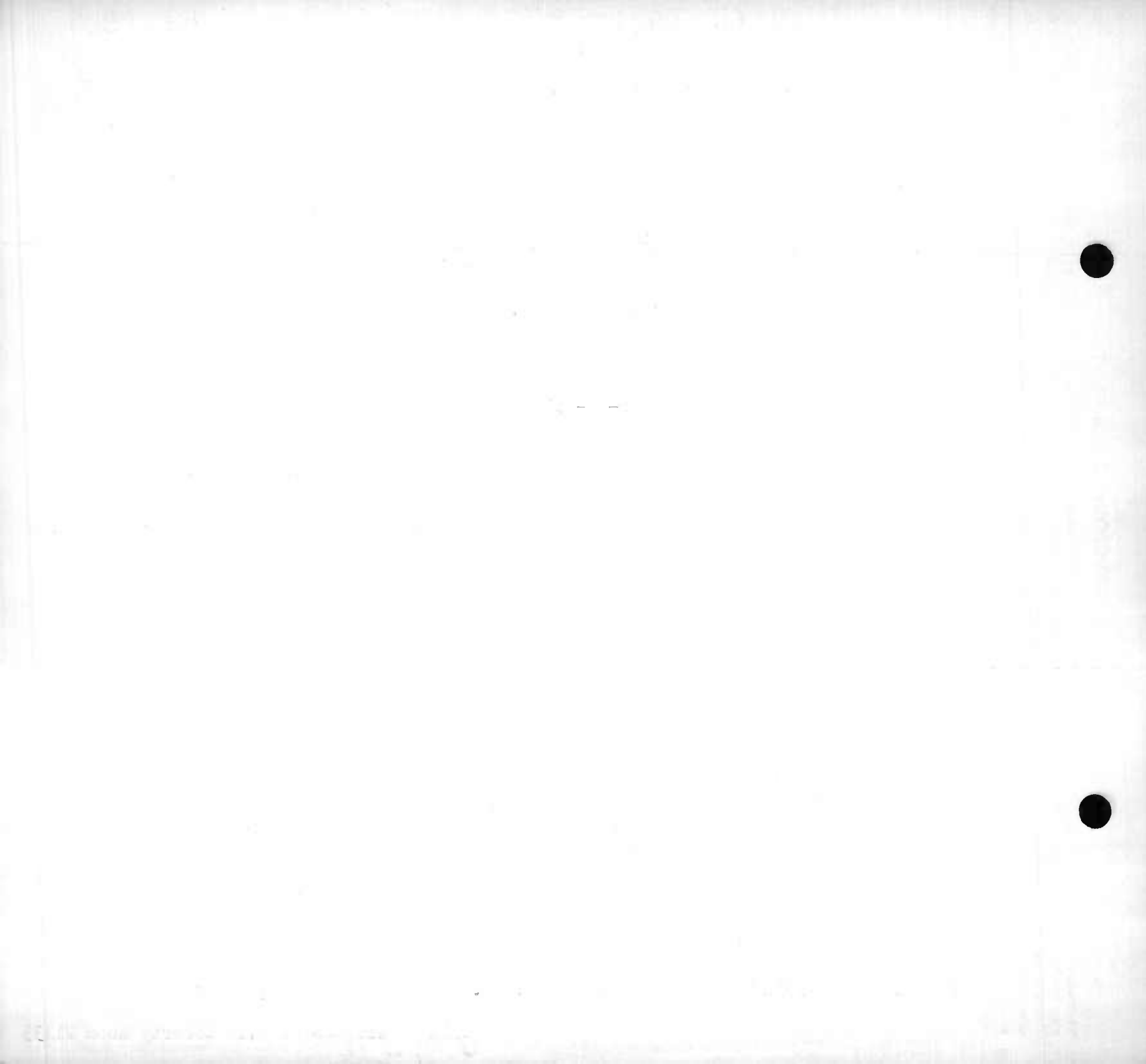
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Margaret Warrington</b>		2. DATE AND HOUR OF DEATH <b>Jan. 23, 1969</b>   <b>5 P.</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>20-03</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1908 Wilkins Ave.</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>1908 Wilkins Ave.</b>					
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 20, 1903</b>	9. AGE (In years last birthday) <b>65 yrs.</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	
13. FATHER'S NAME <b>Richard Oberender</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Schneider</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) <b>no none</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Doris Bechler 2914 Manns Ave. 21234</b>	
18. <b>412.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) <b>arteriosclerotic heart dis.</b> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Nat While <input type="checkbox"/> Work At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan. 21, 1969</b> to <b>Jan. 23, 1969</b> , that (I) (we) last saw the deceased alive on <b>Jan. 21, 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>MORRIS B. SCHREIBER</b>				23B. DATE SIGNED <b>1-24</b>	
23C. PHYSICIAN'S NAME (Type) <b>MORRIS B. SCHREIBER</b>		23D. ADDRESS <b>1519 W. Guilford St. Baltimore Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/27/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Balto. National Cemetery Frederick Rd. Balto. Md.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Schreiner</b>		25C. FUNERAL DIRECTOR ADDRESS <b>KRAUSE FUNERAL HOME 1216 S. Charles St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

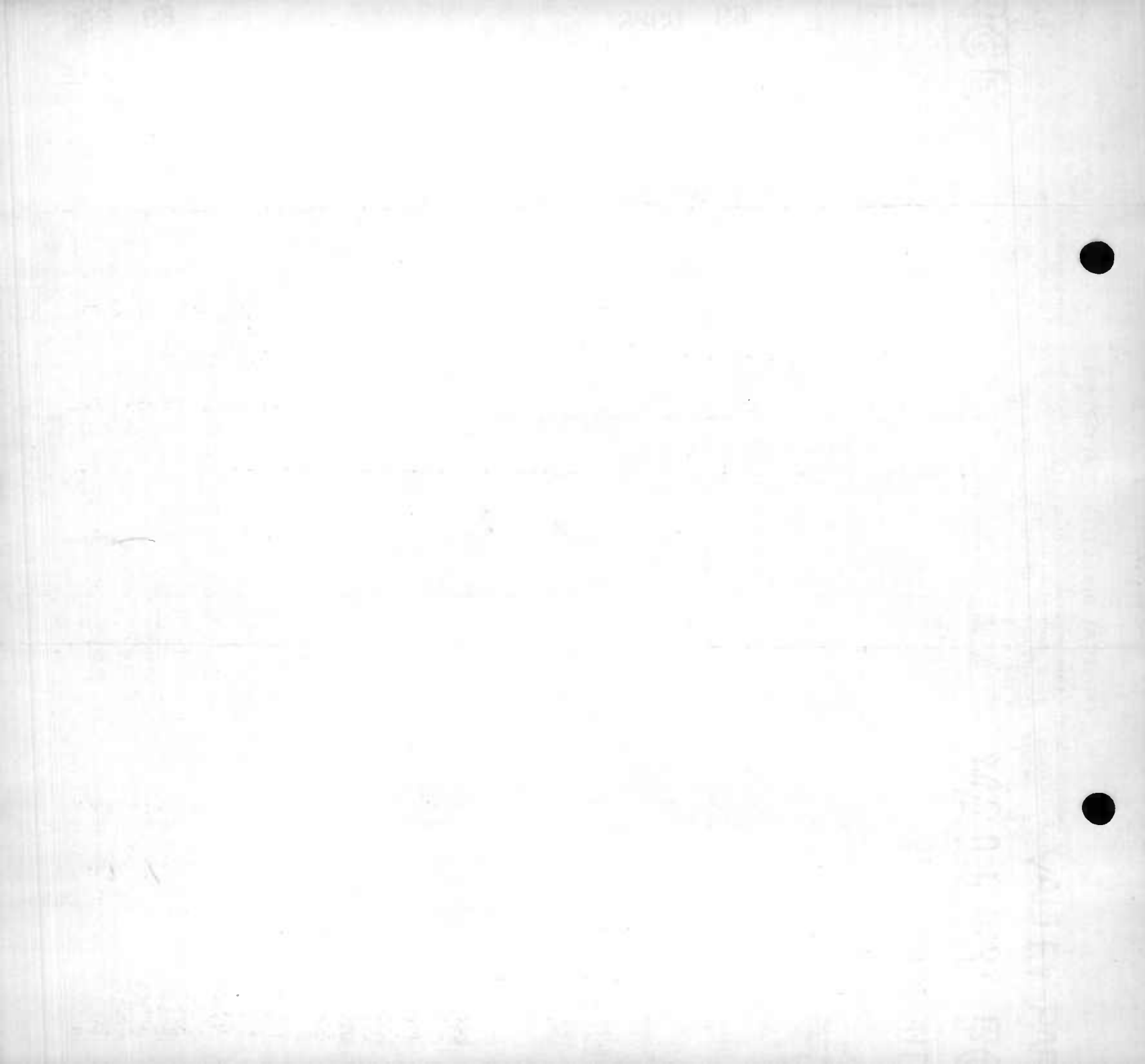
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
69 0925				69 0925	
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		VAN BUSKIRK, HOWARD M.		1/22/69 7 20 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL			A. STATE & COUNTY MD. 12-02		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
44			E. STREET AND NUMBER 118 E 38 RD ST		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/13/97	9. AGE (in years last birthday) 71	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET.		10B. KIND OF BUSINESS OR INDUSTRY Moulton Ladder Co.		11. BIRTHPLACE (State or foreign country) MASS	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME JOHN VAN BUSKIRK		14. MOTHER'S MAIDEN NAME MARJORIE KERRY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 099-09-8529 A		17. INFORMANT ELEANOR M. VAN BUSKIRK	
18. CAUSE OF DEATH		ADDRESS SAME			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE AC MYOCARDIAL INFARCT DUE TO, OR AS A CONSEQUENCE OF: (B) ASCVD DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 d. 20 YEARS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/22 19 69 to 1/22 19 69 that (I) (we) last saw the deceased alive on 1/22 19 69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Charles S. Brown, M.D.				23B. DATE SIGNED 1/22/69	
23C. PHYSICIAN'S NAME (Type) CHARLES S. BROWN, M.D.				23D. ADDRESS UNION MEMORIAL HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/24/69		24C. NAME OF CEMETERY or CREMATORY East Harrisburg, Pa.	
24D. LOCATION Harrisburg, Pennsylvania		24E. DATE REC'D BY HEALTH DEPT. JAN 27 1969		24F. NAME OF REGISTRAR Robert E. Johnson	
24G. FUNERAL DIRECTOR Loring Byers		24H. ADDRESS Chapel 8728 Liberty Road 21133			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68-05070		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 0926	
1. NAME OF DECEASED (Type or Print) Carol Hook.			2. DATE AND HOUR OF DEATH 1/22/69 7:30 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Singer Hospital of Baltimore.			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY 19-03 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1936 Wilhelm St.		
5. SEX Male	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/20/68	9. AGE (In years last birthday) 10 mo	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) U.S.A. - Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME WILLIAM Hook.		
14. MOTHER'S MAIDEN NAME Shirley Jessup.			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No NONE		
16. SOCIAL SECURITY NO. NONE			17. INFORMANT Chart. Singer Hospital		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH a) Aspiration (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: c) Cyanotic Congenital Heart Disease. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/22 1969 to 1/22 1969, that (II) (we) last saw the deceased alive on 1/22 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (IV) (We) (did) (did not) view the body after death.					
23A. SIGNATURE I. Meyer Heller M.D.			23B. DATE SIGNED 1/29/69		
23C. PHYSICIAN'S NAME (Type) I. Meyer Heller			23D. ADDRESS Singer Hospital of Baltimore.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-25-69		24C. NAME OF CEMETERY or CREMATORY MT. OLIVET	
24D. LOCATION Baltimore, Md.		25A. DATE RECEIVED HEALTH DEPT. 1-27-69			
25B. NAME OF REGISTRAR Robert E. Schwegel		25C. FUNERAL DIRECTOR 650 L. Schwab Funeral Home 2101 Frederick Ave.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 69 0927 CERTIFICATE OF DEATH

REG. NO. 69 0927

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>KELLY, WILLIAM A.</b>		2. DATE AND HOUR OF DEATH <b>1/21/69</b> <b>8 30 A</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>12-05</b>		C. CITY OR TOWN <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSP</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>141 E. NORTH AVE.</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 19 1891</b>	9. AGE (In years lost birthday) <b>77</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNEMPLOYED Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Quart-Johnson Co</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>JAMES KELLY</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET RYAN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>AGNES P. KELLY-141 E North Ave</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>GI bleeding</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Esophageal varices.</b> <b>Brachopneumonia, bilateral.</b> <b>Brachiectasia.</b>		CAUSE OF DEATH <b>GI bleeding</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Esophageal varices.</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Brachopneumonia, bilateral.</b> (C) <b>Brachiectasia.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Y.S.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2/1</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>1/20</b> 19 <b>69</b> to <b>1/21</b> 19 <b>69</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>1/20</b> 19 <b>69</b> and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(we)</b> <b>(did)</b> (did not) view the body after death.					
23A. SIGNATURE <b>Charles S. Brown M.D.</b>		23B. DATE SIGNED <b>1/21/69</b>		23C. PHYSICIAN'S NAME (Type) <b>CHARLES S. BROWN M.D.</b>	
23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>1/24/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore</b>		24D. LOCATION (City, town, or county) (State) <b>Belts. Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>H. H. Myers &amp; Son 805 1/2 Calvert St</b>	

17

St. James, N.Y.

James Kelly

My dear Sir,

at New York

Respectfully,  
J. Kelly

Y. 2.

Y. 2.

Y. 2.

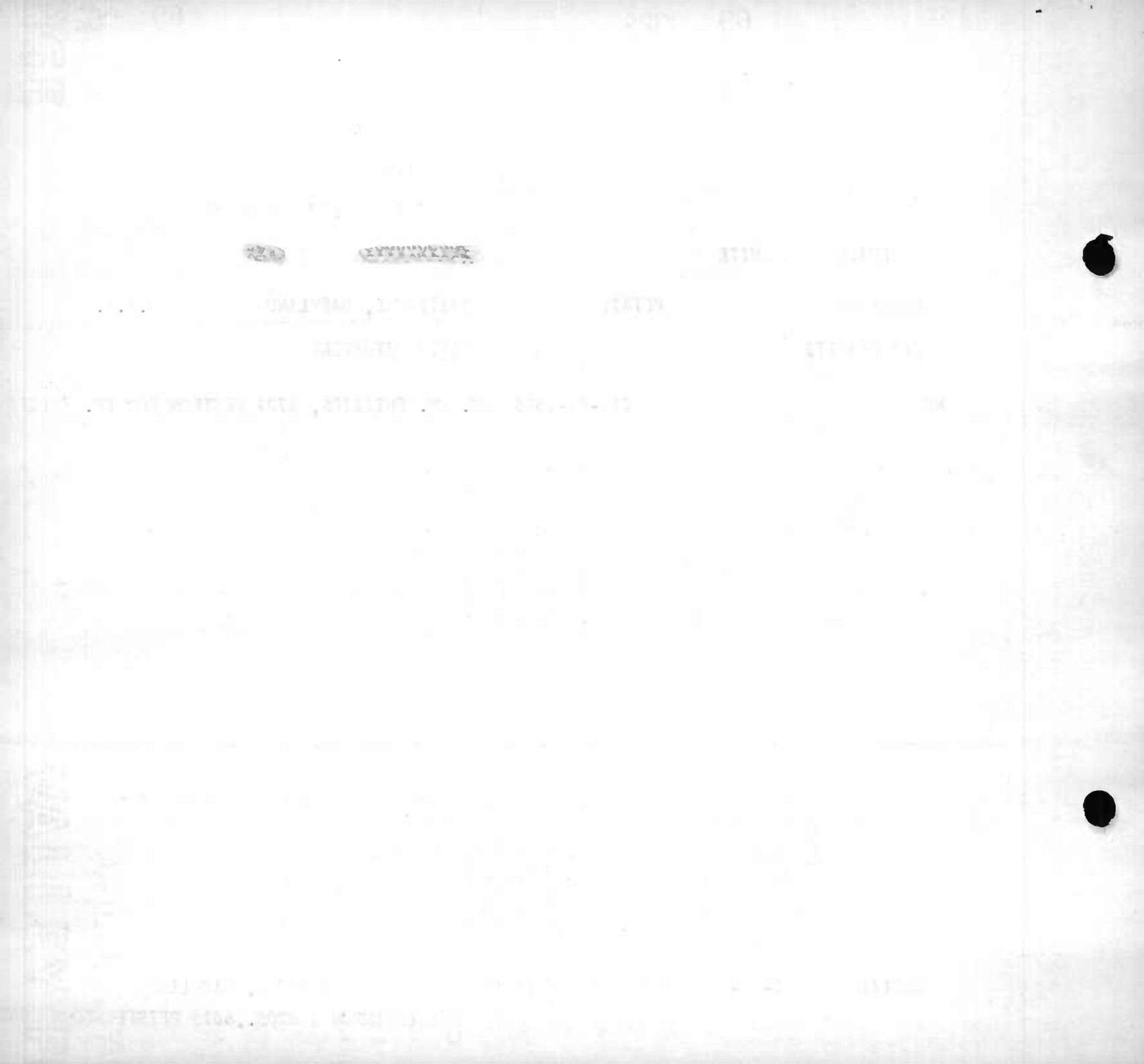
Y. 2.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

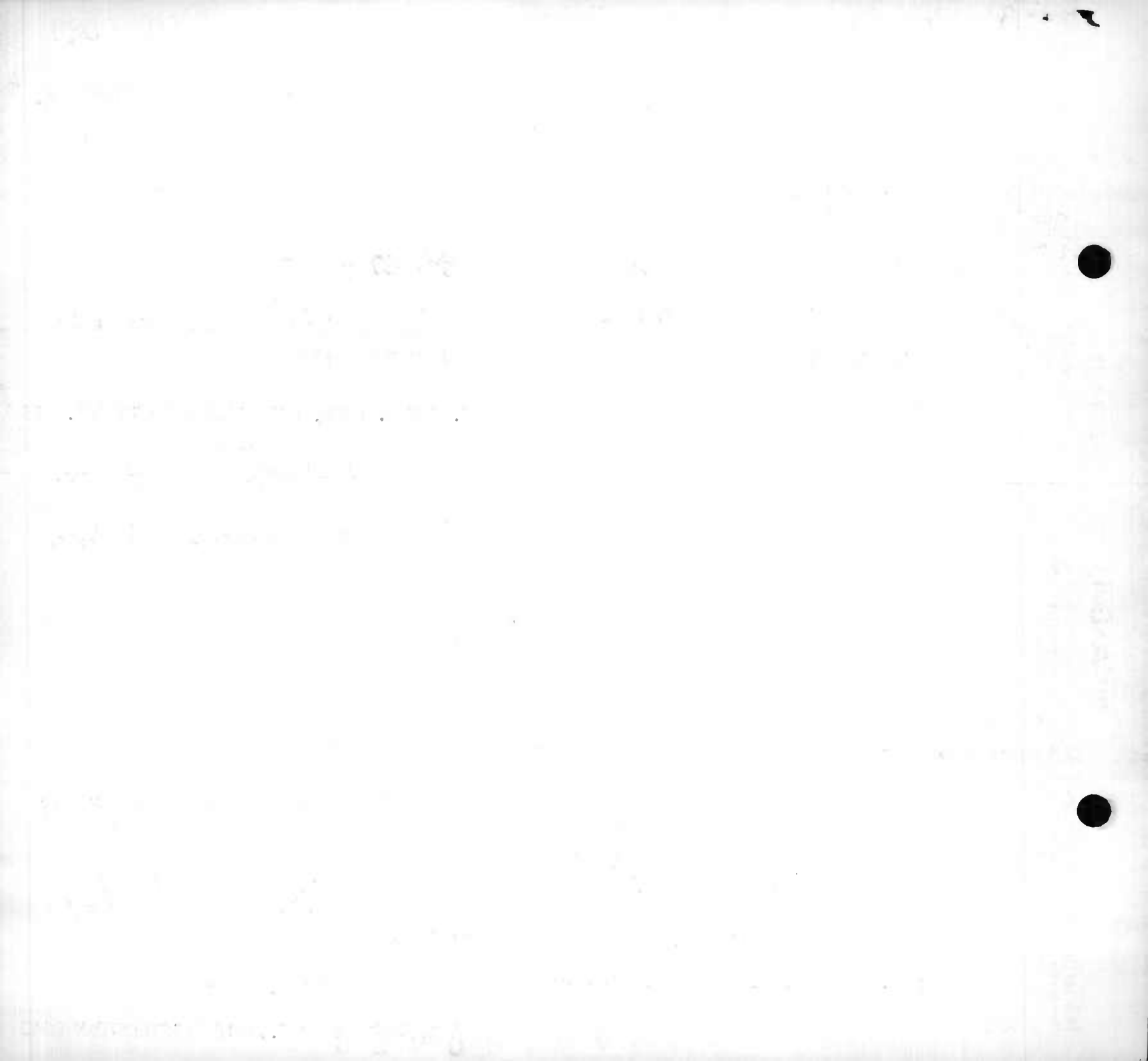
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 0928
K-613		69 0928		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
KRAVITZ, CELE		Jan 22, 69 11 55 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MARYLAND		B. COUNTY 27-30	
42 Sinai Hospital of Baltimore		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		6707 WESTERN RUN DRIVE			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. If Under 1 Yr. Months Days
FEMALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	[REDACTED]	67	[REDACTED]
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
SECRETARY		RETAIL		BALTIMORE, MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
WOLF KRAVITZ		ETTA PATUSTZKY		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		213-05-4555		MR. WM. PHILLIPS, 6707 WESTERN RUN DR. #21215	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		6 days	
		(B) Agranulocytosis DUE TO, OR AS A CONSEQUENCE OF:		6 days	
		(C) _____			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Probable Lymphosarcoma.		?	
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
2		X			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Dec 28 19 68 to Jan 22 19 69, that (I) (we) lost saw the deceased alive on Jan 22 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
J. Lauentman M.D.		[REDACTED]			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
JAIME LAUENTMAN		SINAI HOSPITAL OF BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL	1-24-69	CHIZUK AMUNO (ARLINGTON)		BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
JAN 27 1969	[REDACTED]	SOL LEVINSON & BROS.		6010 REISTERSTOWN ROAD	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

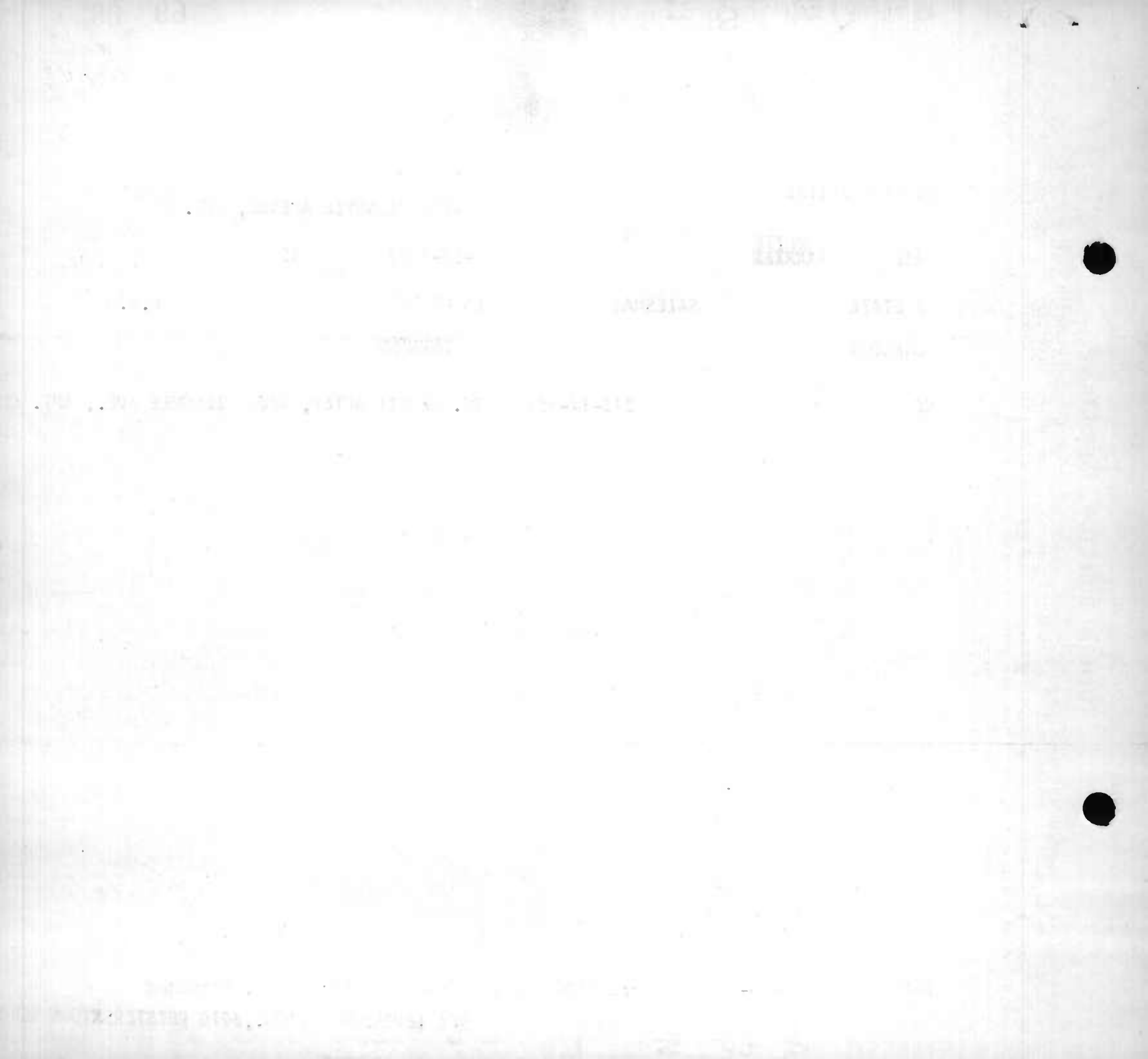
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">69 0929</span>
BIRTH NO. <span style="float: right;">M-620</span>		69 0929 <b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <span style="float: right;">Marcella Myers</span>		2. DATE AND HOUR OF DEATH <span style="float: right;">1/23/69 2:30 A.M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="float: right;">Sinai Hospital</span>		A. STATE <span style="float: right;">Md</span> B. COUNTY <span style="float: right;">27-30</span>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <span style="float: right;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <span style="float: right;">7121 Park Heights Ave.</span>				
5. SEX <span style="float: right;">Female</span>	6. RACE <span style="float: right;">White</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="float: right;">7/21/1914</span>	9. AGE (In years last birthday) <span style="float: right;">54</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="float: right;">Housewife</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="float: right;">AT HOME</span>		11. BIRTHPLACE (State or foreign country) <span style="float: right;">New York</span>
12. CITIZEN OF WHAT COUNTRY? <span style="float: right;">U.S.A.</span>				
13. FATHER'S NAME <span style="float: right;">LESTER COHN</span>		14. MOTHER'S MAIDEN NAME <span style="float: right;">ANNA FREUNDLICH</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="float: right;">NO</span>		16. SOCIAL SECURITY NO.		17. INFORMANT <span style="float: right;">MRS. ANN M. KATZ, 6615 PARK HEIGHTS AVE. #15</span>
18. <span style="float: right;">410.91</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  1. This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="float: right;">Shock Schock</span>  (B) <span style="float: right;">Myocardial Infarction</span> DUE TO, OR AS A CONSEQUENCE OF:  (C) <span style="float: right;">None</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  <span style="float: right;">8 hrs.</span>  <span style="float: right;">8 hrs.</span>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <span style="float: right;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="float: right;">Yes</span>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <span style="float: right;">1:50 P.M. 1/22 19 69</span> to <span style="float: right;">2:30 A.M. 1/23 19 69</span> that (I) (we) last saw the deceased alive on <span style="float: right;">1/23</span> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <span style="float: right;">Robert D. Brull</span>		23B. DATE SIGNED <span style="float: right;">1/23/69</span>		
23C. PHYSICIAN'S NAME (Type) <span style="float: right;">ROBERT BRULL</span>		23D. ADDRESS <span style="float: right;">SINAI HOSPITAL</span>		
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="float: right;">BURIAL</span>		24B. DATE <span style="float: right;">1-24-69</span>		24C. NAME OF CEMETERY or CREMATORY <span style="float: right;">BALTIMORE HEBREW</span>
24D. LOCATION (City, town, or county) (State) <span style="float: right;">BALTIMORE, MARYLAND</span>				
25A. DATE REC'D BY HEALTH DEPT. <span style="float: right;">JAN 27 1969</span>		25B. NAME OF REGISTRAR <span style="float: right;">Robert D. Brull</span>		25C. FUNERAL DIRECTOR <span style="float: right;">SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</span>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">69 0930</span>	
<div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">A-136</span> <span style="font-size: 1.5em;">69 0930</span> <span style="font-size: 1.5em;">CERTIFICATE OF DEATH</span> </div>					
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Maurice Apter</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">Jan 21 1969 9.04p M.</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">SINAI HOSPITAL</span>		A. STATE <span style="font-size: 1.2em;">MARYLAND</span>		B. COUNTY <span style="font-size: 1.2em;">27-20</span>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<span style="font-size: 1.2em;">4-21</span>		E. STREET AND NUMBER <span style="font-size: 1.2em;">4000 GLENGYLE AVENUE, APT. C</span>			
5. SEX <span style="font-size: 1.2em;">MALE</span>	6. RACE <span style="font-size: 1.2em;">WHITE</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">6-23-1903</span>	9. AGE (In years lost birthday) <span style="font-size: 1.2em;">65</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">R ETAIL</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">SALESMAN</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">EN GLAND</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">UNKNOWN</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">UNKNOWN</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">215-14-9250</span>		17. INFORMANT <span style="font-size: 1.2em;">MRS. BESSIE APTER, 4000 GLENGYLE AVE., APT. C</span>	
18. <span style="font-size: 1.2em;">4/12/69</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <span style="font-size: 1.2em;">Cardiac standstill</span> DUE TO, OR AS A CONSEQUENCE OF: (B) <span style="font-size: 1.2em;">Arteriosclerotic Heart Disease</span> DUE TO, OR AS A CONSEQUENCE OF: (C) <span style="font-size: 1.2em;">years</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">sudden</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <span style="font-size: 1.2em;">Familial Hypercholesterolemia</span>		<span style="font-size: 1.2em;">congenital</span>			
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2/1</span>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">Yes</span>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <span style="font-size: 1.2em;">no</span>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">12/18</span> 19 <span style="font-size: 1.2em;">65</span> to <span style="font-size: 1.2em;">1/21</span> 19 <span style="font-size: 1.2em;">69</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">1/6</span> 19 <span style="font-size: 1.2em;">69</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Louis V. Blum, M.D.</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">1/22/69</span>		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Louis V. Blum, M.D.</span>	
23D. ADDRESS <span style="font-size: 1.2em;">3502 W. Rogers Ave, Baltimore Md 21211</span>		23E. NAME OF REGISTRAR <span style="font-size: 1.2em;">JAN 27 1969</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">BURIAL</span>	24B. DATE <span style="font-size: 1.2em;">1-23-69</span>	24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">(JOEL YAKOV) BETH ISRAEL</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">BALTIMORE, Maryland</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JAN 27 1969</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">SQL LEVINSON &amp; BROS.</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">6010 REISTERS TOWN RD</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0931

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

69 0931

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Anna Barron

2. DATE AND HOUR OF DEATH

Jan. 21, 1969 8<sup>30</sup> P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

377 Mercy Hospital

4. USUAL RESIDENCE where deceased lived. If institution residence before admission)  
A. STATE B. COUNTY

MD.

C. CITY OR TOWN  
BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

3700 FAIT AVE. #21224.

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

AUG. 3, 1892

9. AGE (in years last birthday)

76

10. Under 1 Yr. 11. Under 24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

OPERATOR

10B. KIND OF BUSINESS OR INDUSTRY

ALLON MFG. CO.

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MD.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

MICHAEL DUNKES

14. MOTHER'S MAIDEN NAME

LOUISE GIESENREGEN.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

213-28-8922

17. INFORMANT

AUDREY M. HINKEL 3504 CLIFTMONT AVE. BALTO, 21213, MD.

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

SEPSIS

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

Dec. 5, 1968

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

Urolithiasis

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov. 28, 1968 to Jan. 21, 1969 that (I) (we) last saw the deceased alive on Jan. 21, 1969 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Chang Shee Chang, M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

Jan. 21, 1969

23C. PHYSICIAN'S NAME (Type)

CHANG-SHEE CHANG, M.D.

23D. ADDRESS

Mercy Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

1-25-69.

24C. NAME OF CEMETERY or CREMATORY

OAK LAWN CEM.

24D. LOCATION

(City, town, or county)

(State)

7225 EASTERN BLVD., BA. CO., MD

25A. DATE REC'D BY HEALTH DEPT.

JAN 27 1969

25B. NAME OF REGISTRAR

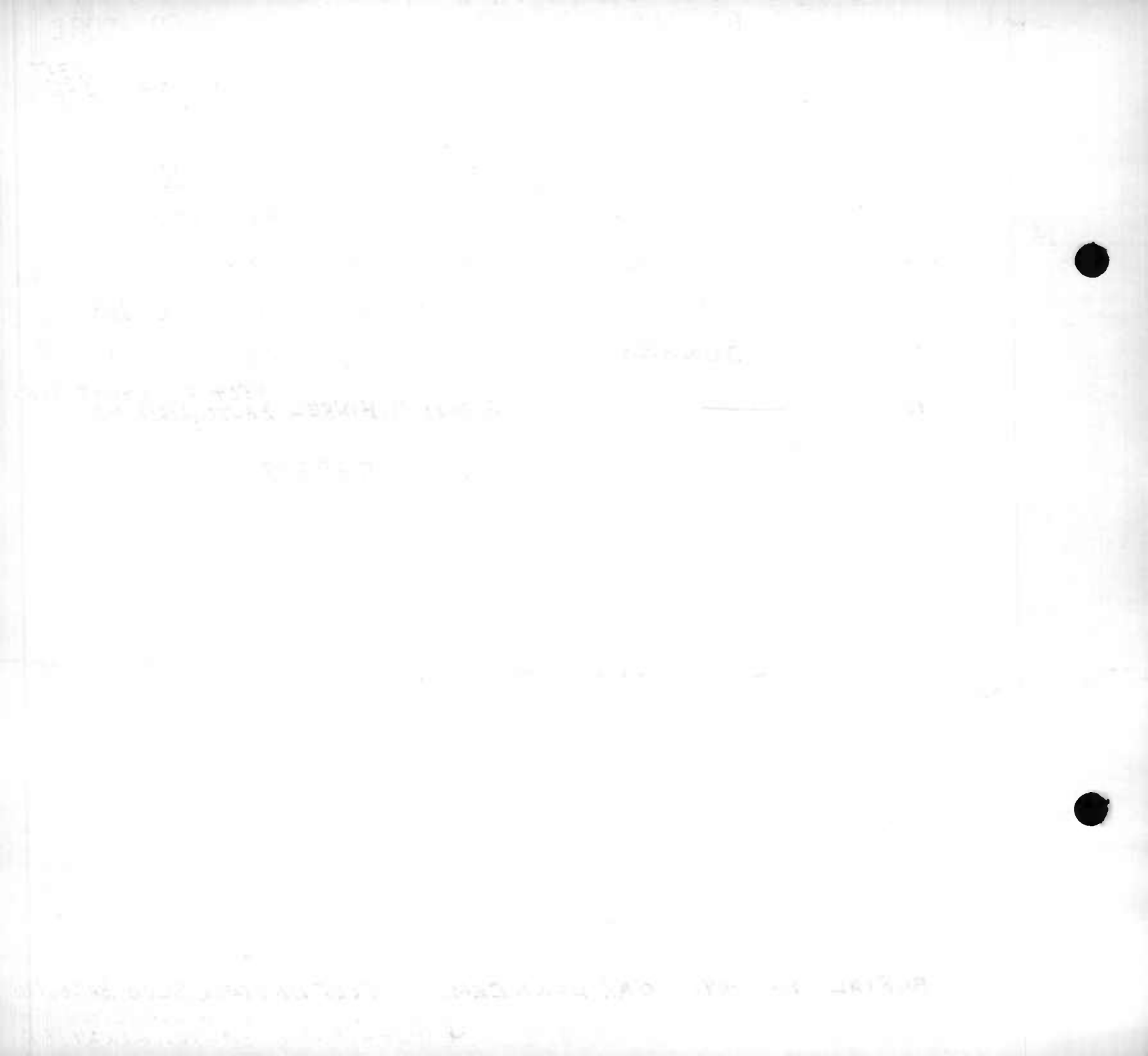
Robert E. [illegible]

25C. FUNERAL DIRECTOR

Charles A. Guler

25D. ADDRESS

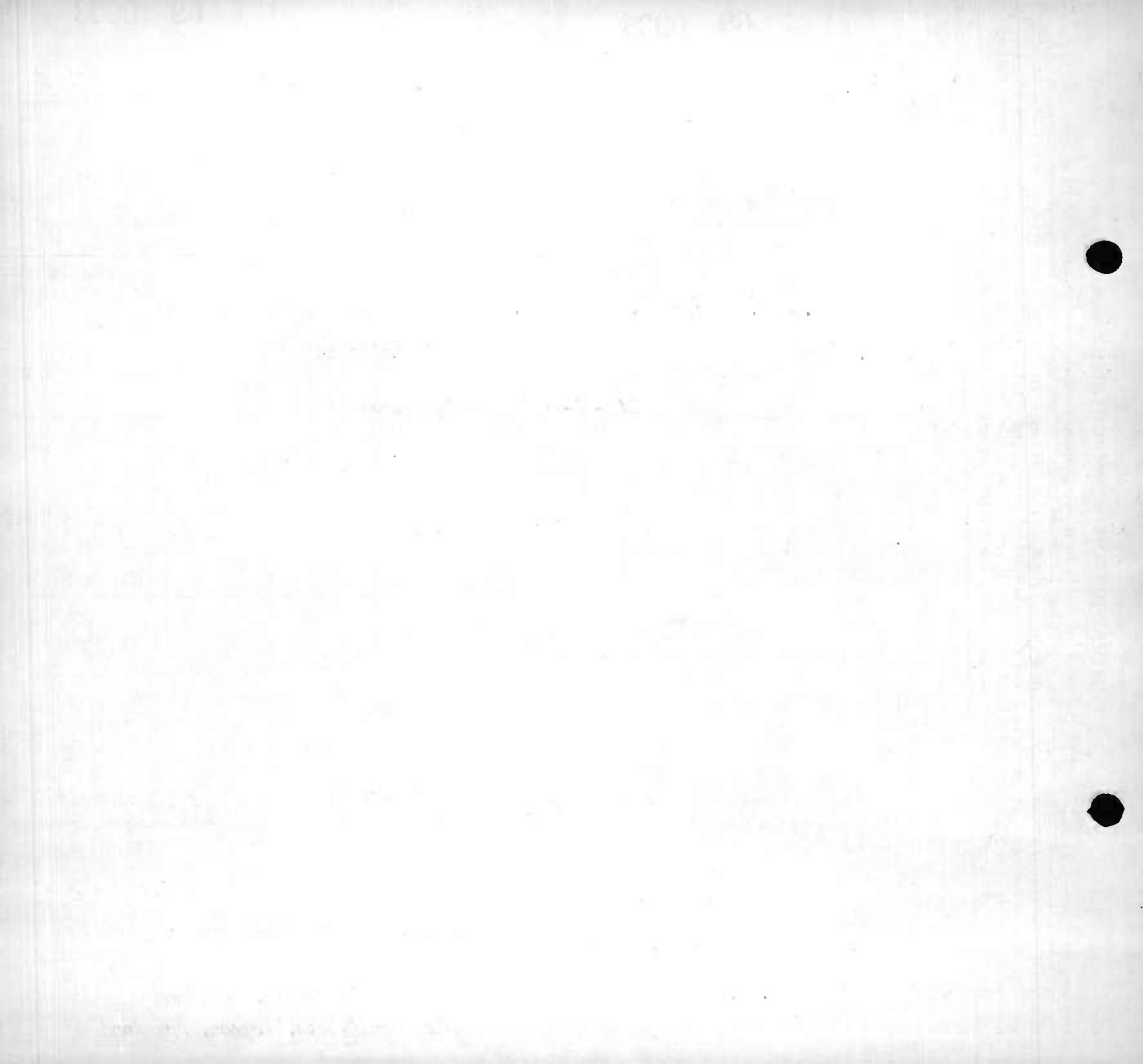
901 S. CONKLING ST., BALTO., 21224, MD.





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>RAYMOND BRITCHER CLARK</b>		2. DATE AND HOUR OF DEATH <b>1/22/69 10:45 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b> <b>53-00</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>MARYLAND GENERAL 48 HOSPITAL</b>				C. CITY OR TOWN <b>TOWSON</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <b>7914 KNOWWOOD RD. APT. D</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>03/26/04</b>	9. AGE (In years lost birthday) <b>64</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Personel Dept. - Ret.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Glenn L. Martin Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>James R. Clark</b>				14. MOTHER'S MAIDEN NAME <b>Bessie Britcher</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO. <b>212-01-2744</b>		17. INFORMANT <b>Family Records</b>	
18. <b>4/12/69 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>CARDIAC ARREST</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <b>CORONARY HEART DISEASE</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1/22/69</b> 19 <b>69</b> to <b>1/22</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>1/22</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Artemio M. Cuevas, Jr. M.D.</b>				23B. DATE SIGNED <b>1/22/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>ARTEMIO M. CUEVAS, JR. M.D.</b>				23D. ADDRESS <b>MARYLAND GENERAL HOSP.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Jan. 25, 1969</b>		24C. NAME of CEMETERY or CREMATORY <b>Druid Ridge Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Pikesville, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>			
25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR <b>John Burns &amp; Sons, Towson, Maryland</b>			



FUNERAL DIRECTOR: IMPORTANT

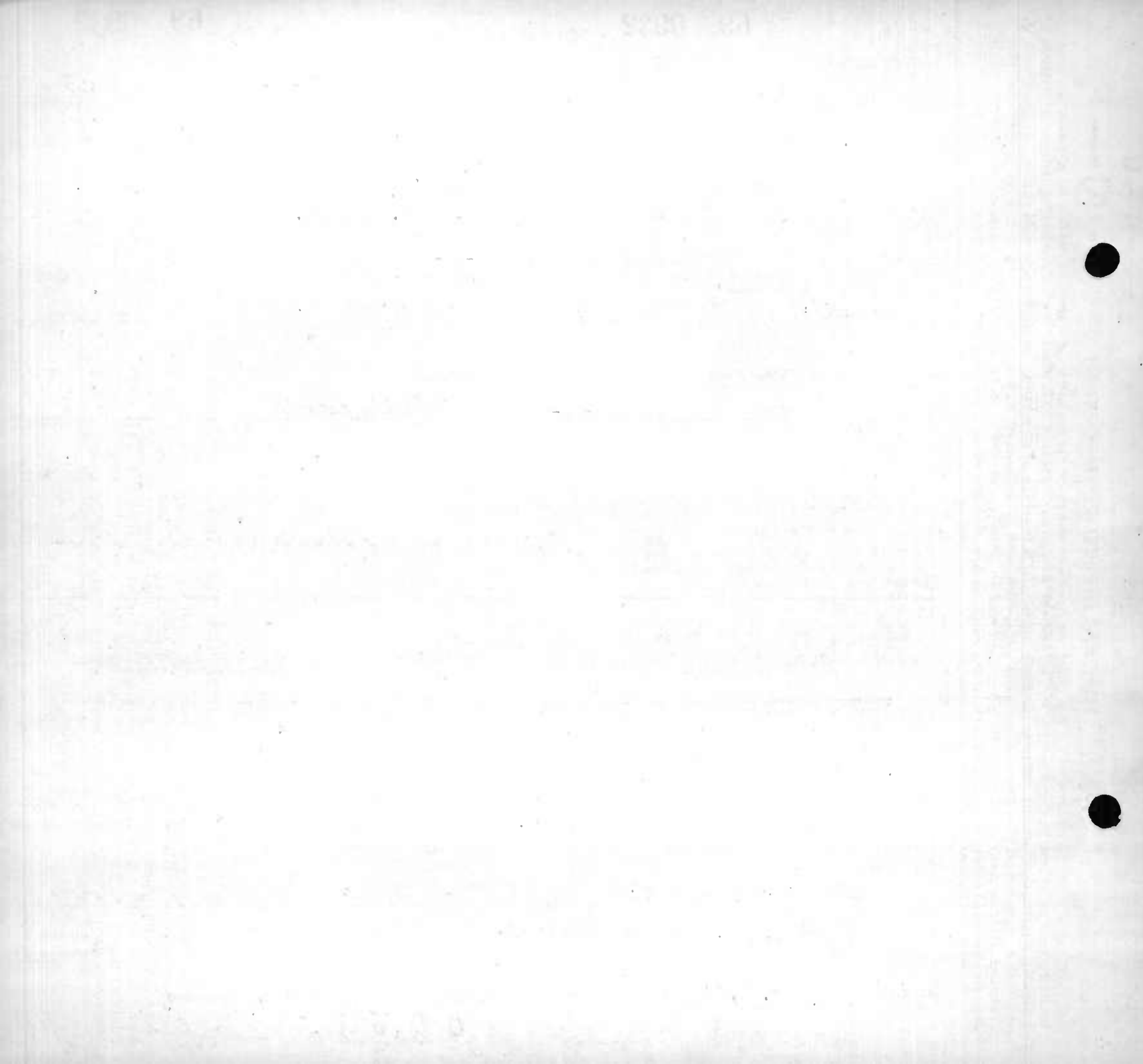
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0932

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 0932

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Dolores Corcoran		1-22-69 12:55 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 90 Bolton Hill Nursing & Convalescent Center				A. STATE Maryland	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. CITY OR TOWN Balto.	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3120 St. Paul St.	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-24-98	9. AGE (In years last birthday) 70
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None				16. SOCIAL SECURITY NO. 215-05-6280	
17. INFORMANT Family records				ADDRESS	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.21 Cerebral Thrombosis					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) Hypertensive CV disease					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/15 19 68 to 1/22 19 69, that (I) (we) last saw the deceased alive on 1/22 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. H. MACHIN				23B. DATE SIGNED 1/23/69	
23C. PHYSICIAN'S NAME (Type) ALLAN H. MACHIN				23D. ADDRESS 2 E READ ST BALTIMORE MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan. 24, 1969		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION Baltimore, Maryland		24E. (City, town, or county)		24F. (State)	
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1969		25B. NAME OF REGISTRAR John E. Jones		25C. FUNERAL DIRECTOR John E. Jones	
ADDRESS					



# FUNERAL DIRECTOR: IMPORTANT

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69 0934

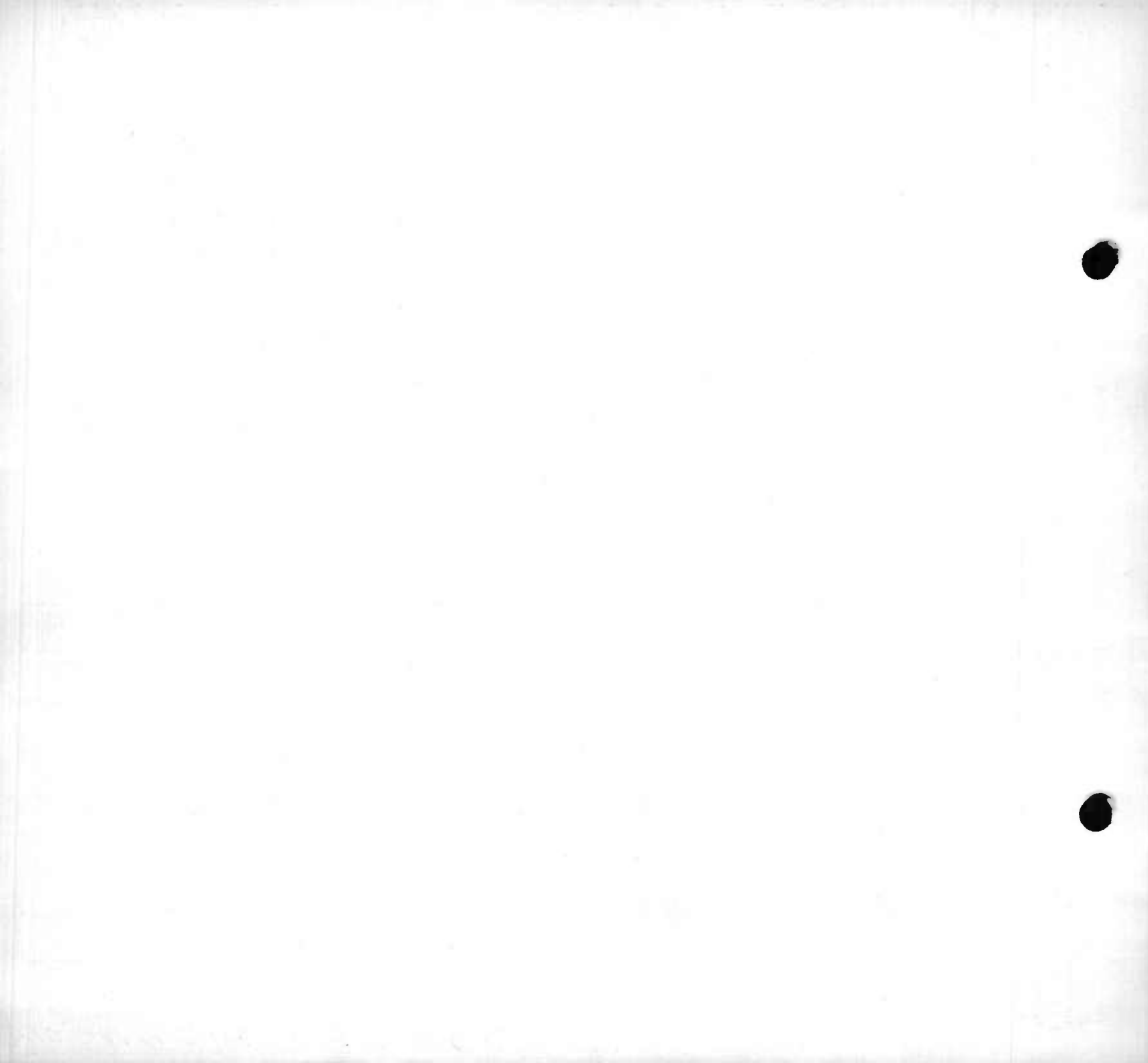
BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

69 0934

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>TOWNS, NORMAN</u>		2. DATE AND HOUR OF DEATH <u>1/25/69</u> <u>1 10 45 P</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALT. CITY</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIV. OF MD. HOSPITAL</u>			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <u>501 MT HOLLY ST</u>		
5. SEX <u>♂</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/16/13</u>	9. AGE (In years last birthday) <u>55</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>BETN. STEEL</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
13. FATHER'S NAME <u>WALTER TOWNS</u>			14. MOTHER'S MAIDEN NAME <u>MINERVA MANOORD</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-10-1146</u>		17. INFORMANT <u>DOROTHY TOWNS</u>	
18. <u>42751</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>CARDIO - PULM. ARREST</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>VENTRICULAR TACHYCARDIA</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 NR 45 MIN</u>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1/25/69</u> 19 <u>69</u> to <u>1/25</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>1/25</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Michael J. Deegan Jr MD</u>				23B. DATE SIGNED <u>1/25/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>DEGAN</u>				23D. ADDRESS <u>UNIV. OF MD HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-29-69</u>		24C. NAME of CEMETERY or CREMATORY <u>MT. CALVERY</u>	
24D. LOCATION (City, town, or county) (State) <u>BROOKLYN, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 27 1969</u>			
25B. NAME OF REGISTRAR <u>Deegan, Michael J.</u>		25C. FUNERAL DIRECTOR <u>CHARLES A. ROE</u>			
25D. ADDRESS <u>661 W. BARRE ST.</u>					



m-244

69 0935 BALTIMORE CITY HEALTH DEPARTMENT

69 0935

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		MILDRED MC CLELLAND		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year		Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		University Hospital (DOA)		3. DATE PRONOUNCED DEAD		Month Day Year		Hour	
				January 22, 1969		4:55 P.		M.	
6. SEX		7. RACE		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
Female		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		A. STATE		B. COUNTY	
						Maryland		21-01	
9. DATE OF BIRTH		10. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
4-12-11		57		Maryland		U.S.A.		Grant Grimes	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
				Mary		no		Nathaniel McClelland	
19. 412.4		CAUSE OF DEATH		Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:							
		(C) DUE TO, OR AS A CONSEQUENCE OF:							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)					
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?					
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							
23.									
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type)		Charles S. Springate, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				January 23, 1969	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		1-27-69		Mt. Auburn		Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JAN 27 1969		Robert E. Fairburn		Charles A. Rice		661 W. Barre St.			

WALTER BOWEN

ASSISTANT CLERK

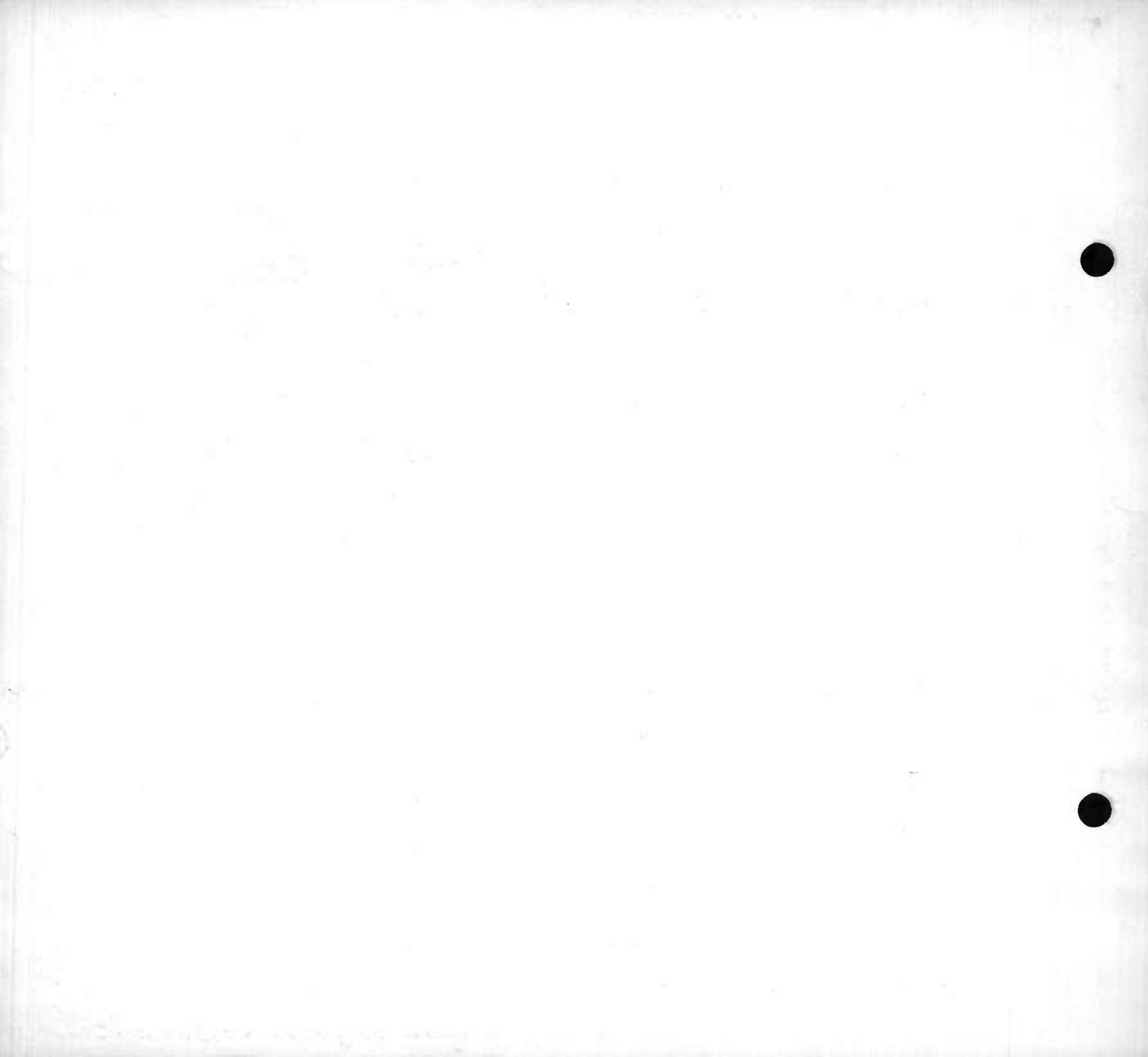
1-27-78



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="float: right;">69 0936</span>
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH
		ROLAND ROLES		1-25-69 11.30P M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  THE JOHNS HOPKINS HOSPITAL 33		A. STATE B. COUNTY		
		MARYLAND BALTIMORE CITY 7-03		
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER		
		2241 McELDERRY STREET 21205		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
MALE	NEGRO		2-7-14	34
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
None		Race Trade		MD
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
HERBERT ROLES		VIOLETTA HENRY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT
No		218-05-3046		Dean Roles 2241 Mc Elderry St
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		One month
ANTECEDENT CAUSES		Esophageal Carcinoma with Metastases		6 mos.
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		(C) DUE TO, OR AS A CONSEQUENCE OF:		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
Aug. 1968	Esophageal Carcinoma	No		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR?	(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?		
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from Jan 2 19 69 to Jan 25 19 69 that (1) (we) last saw the deceased alive on Jan 25 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE		23B. DATE SIGNED		
Douglas T. Fearon, M.D.		Jan 25, 1969		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
DOUGLAST. FEARN, M.D.		Johns Hopkins Hospital, Balt. Md.		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county)	(State)
BURIAL	1/30/69	Int. Colman	Baltimore, Md	21205
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS	
JAN 27 1969	R. E. E. E. E.	Johns Hopkins Hospital	2130 17. Central Ave	



69 0937

BALTIMORE CITY HEALTH DEPARTMENT

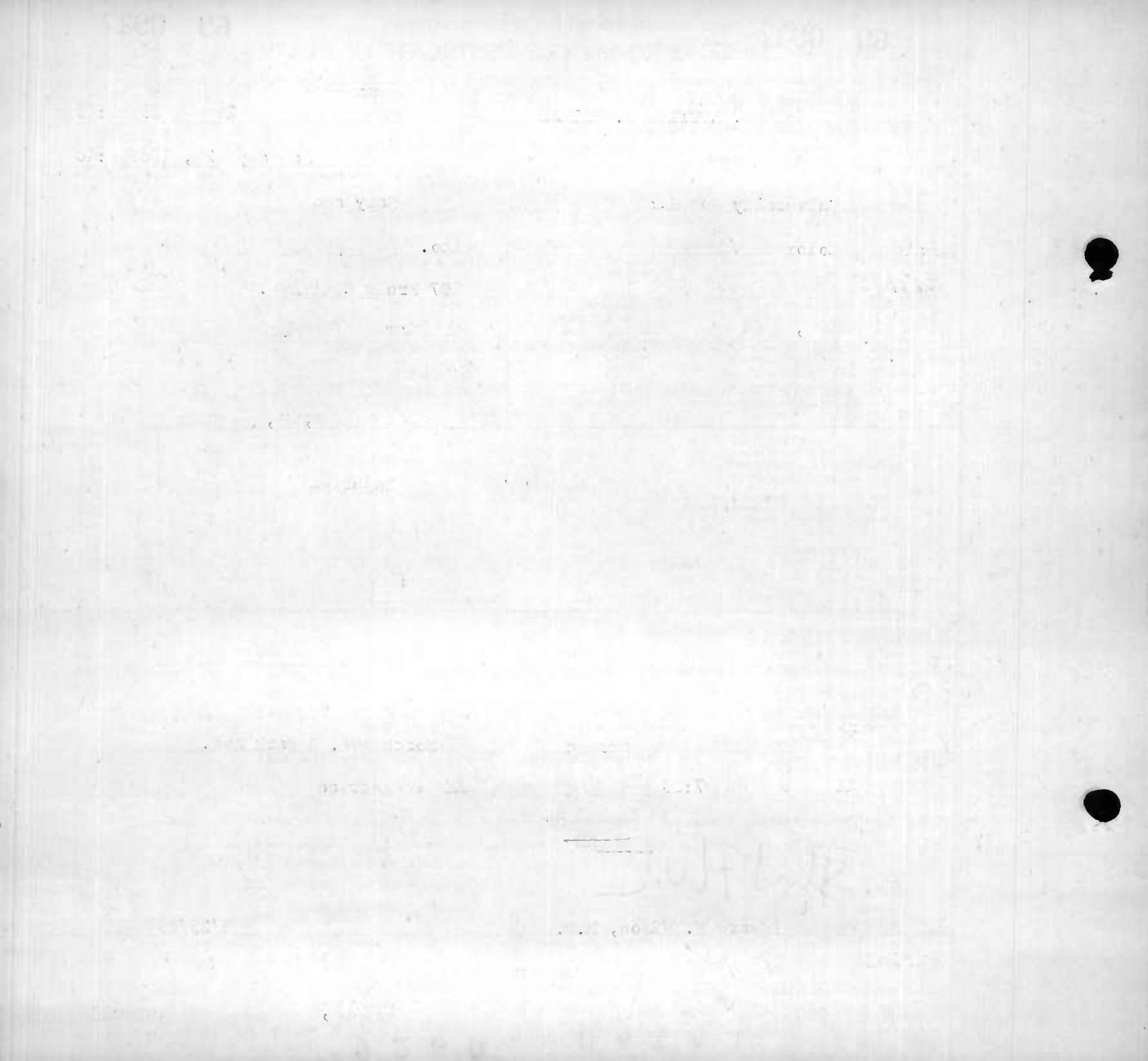
69 0937

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

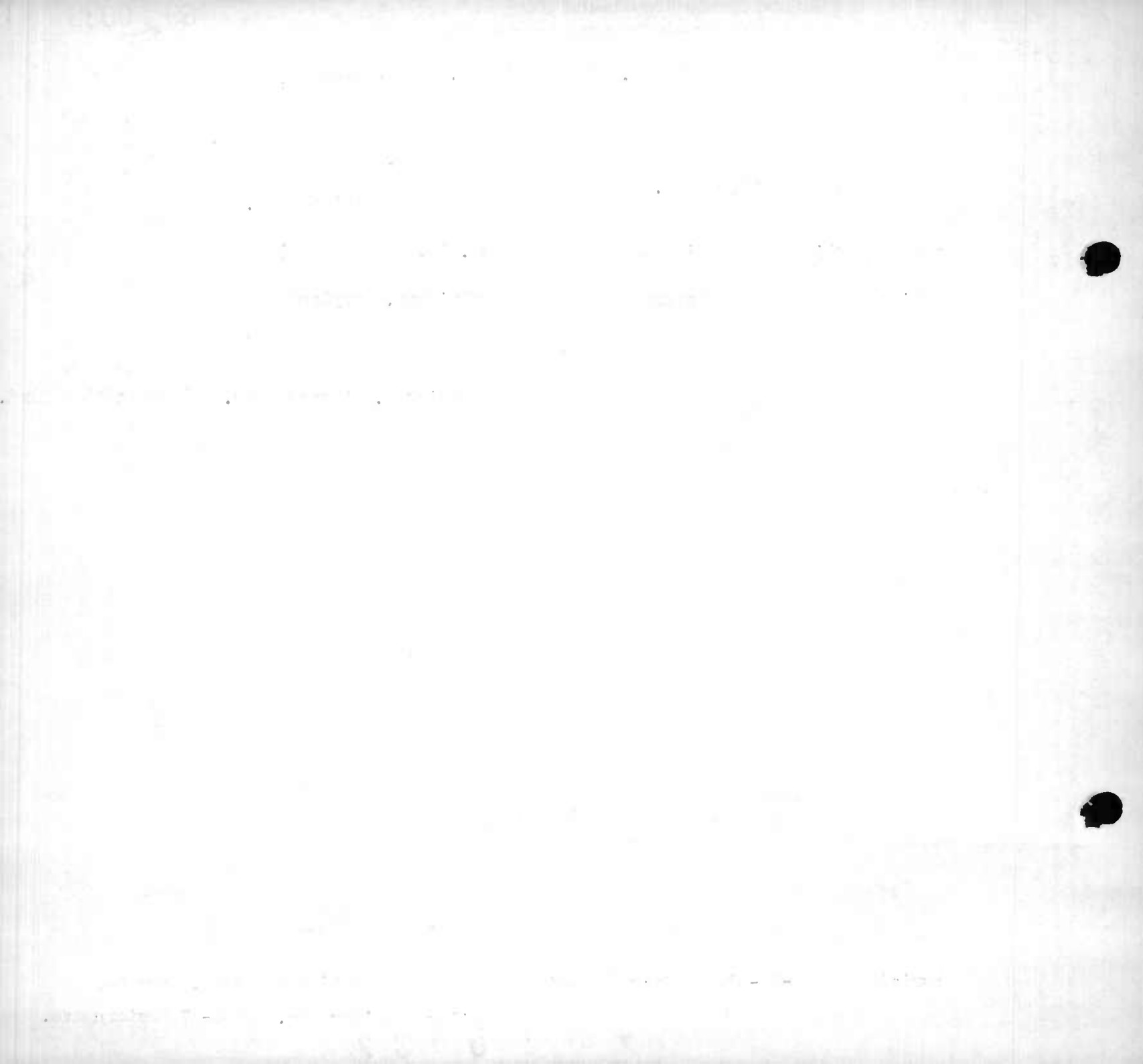
1. NAME OF DECEASED (Type or Print) <b>LETTIE (LOTTIE) H. HAYMAN</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>1 24 69 8:15 p.m.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>38 University Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 24, 1969 8:15 p.m.</b>	
6. SEX <b>Female</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____	
7. RACE <b>Colored</b>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>5/7/23</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) <b>45</b>		E. STREET AND NUMBER <b>807 Druid Hill Ave. 17-02</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William Hayman</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>	
14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>Sadie</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO. _____	
18. INFORMANT <b>Mrs Sadie Hayman,</b>		ADDRESS <b>same</b>	
19. <b>E814.7</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>INJURIES</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Injuries</b> (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____	
21. AUTOPSY? (Yes or No) <b>0</b>		22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>North Ave. &amp; Park Ave. 13-02</b>	
22D. TIME OF INJURY (APPROX.) <b>11 6 68 7:55</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? <b>Pedestrian</b>		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Edward F. Wilson</b> M.D. EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1/25/69</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/30/69</b>	
24C. NAME of CEMETERY or CREMATORY <b>MT Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>	
25C. FUNERAL DIRECTOR <b>I Carroll,</b>		ADDRESS <b>Halstead Funeral Home 1206 W North Ave</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		69 0938		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.		69 0938	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
				FREDERICK A. STRASSNER SR.				January 25, 1969	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				M.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE Maryland				B. COUNTY	
00 4905 Walther Blvd.				C. CITY OR TOWN (If outside city limits, write RURAL and give township)				27-41	
				D. STREET ADDRESS (If rural, give location)				4905 Walther Blvd.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
Male	White	WIDOWED, DIVORCED (specify) Widowed	Aug. 10, 1890	78	Retired	Tavern Owner	Baltimore, Maryland		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT			
						Frederick A. Strassner Jr. 4905 Walther Blvd.			
18. 412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH Intensio-sclerotic heart disease				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO					
				(B) DUE TO					
				(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from Jan. 19 67 to 1/25 19 69, that (I) ( <del>was</del> ) last saw the deceased alive on 1/18 19 69 and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) ( <del>did</del> ) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
Joseph R. Strassner				1/27/69					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
JOSEPH R. ALBERTO				3508 BARK ST. Baltimore, Maryland					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		1-28-1969		Sacred Heart		Baltimore County, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JAN 27 1969		Robert A. Strassner		Lilly & Zeiler Inc.		1901-07 Eastern Ave.			



FUNERAL DIRECTOR: IMPORTANT

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# BALTIMORE CITY HEALTH DEPARTMENT 69 0939 CERTIFICATE OF DEATH

REG. NO. 69 0939

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ROBERT JOHNSON</b>		2. DATE AND HOUR OF DEATH <b>Jan 22, 1969 11<sup>10</sup> P M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>33 THE JOHNS HOPKINS HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE CITY</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1923 E. PRESTON STREET 21213</b>		
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-12-03</b>	9. AGE (In years lost birthday) <b>65</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Steel Co. Blackstock, S.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ADAM JOHNSON</b>			14. MOTHER'S MAIDEN NAME <b>HESTER</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-075125</b>		17. INFORMANT <b>Mable Johnson 1923 E. Preston St.</b>	
18. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Anoxia</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>MYOCARDIOPATHY</b>			DUE TO, OR AS A CONSEQUENCE OF: <b>10 yrs</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>D - Sepsis E - Gastrointestinal bleeding &amp; obstruction F - Renal tubular necrosis</b>			<b>20 yrs</b>		
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>1/18/69</b> to <b>1/22/69</b> and that (1) (we) last saw the deceased alive on <b>1/22/69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Wm. W. Lukemeyer M.D.</b>				23B. DATE SIGNED <b>1/22/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>WILLIAM W. LUKEMEYER</b>				23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-27-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Anne Arundel Co., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>			
25B. NAME OF REGISTRAR <b>John J. Johnson</b>		25C. FUNERAL DIRECTOR <b>Randolph J. Carlick 2431 E. Oliver St.</b>			

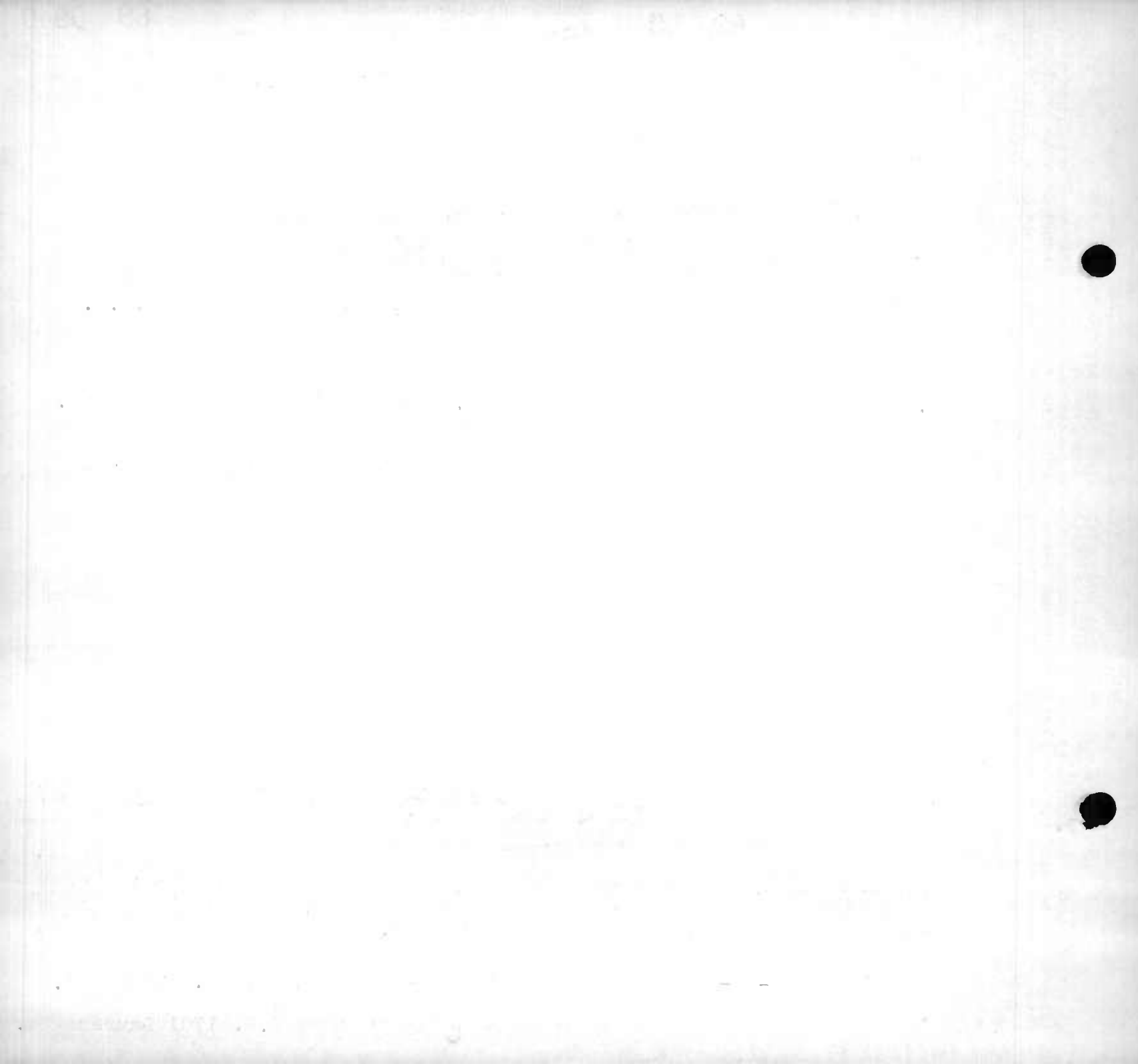




# FUNERAL DIRECTOR: IMPORTANT

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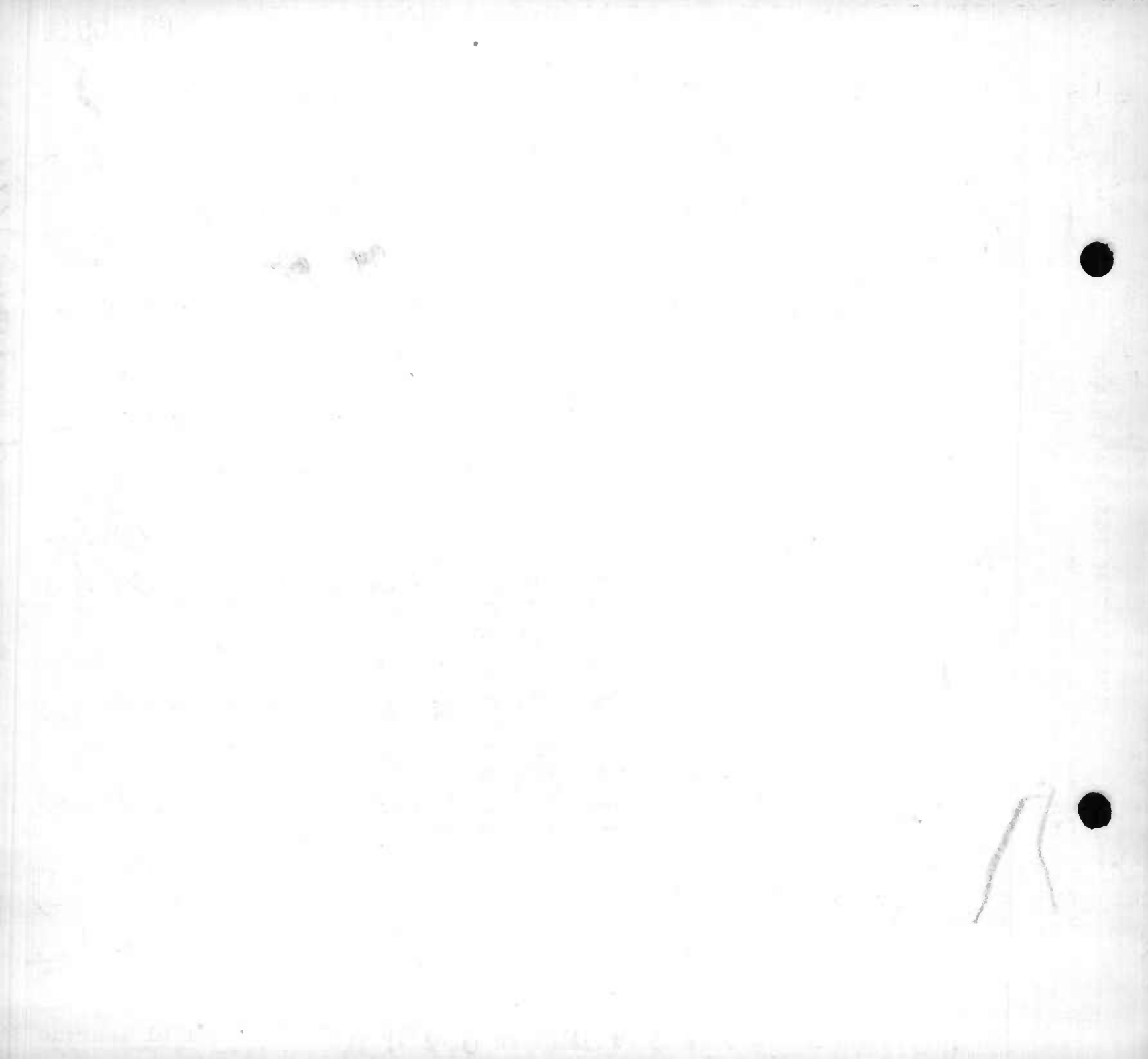
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
69 0940		69 0940		69 0940	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
MATTIE ANN SMITH		January 23, 1969		M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  00 827 Harlem Avenue		A. STATE MARYLAND B. COUNTY 17-03			
5. SEX Female		6. RACE Negro		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	
8. DATE OF BIRTH Nov, 14, 1882		9. AGE (In years last birthday) 86		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
11. BIRTHPLACE (State or foreign country) Ruffin, North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edward Pride	
14. MOTHER'S MAIDEN NAME Emily Pride		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Edward Smith		ADDRESS 827 Harlem Ave.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH A. DUE TO Cardiovascular Disease B. DUE TO Stroke C. DUE TO		INTERVAL BETWEEN ONSET AND DEATH Unknown 6 weeks	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec 21 1968 to Jan 23 1969, that (I) (we) last saw the deceased alive on Jan 20 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE William H. W. H.		23B. DATE SIGNED 1/24-69	
23C. PHYSICIAN'S NAME (Type) William H. W. H.		23D. ADDRESS 515 N. Fort Myer Ave Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-28-69		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park	
24D. LOCATION Arbutus, Maryland		25A. DATE REC'D BY HEALTH DEPT. Jan 27 1969		25B. NAME OF REGISTRAR MORTON S. DUBETT	
25C. FUNERAL DIRECTOR MORTON S. DUBETT		ADDRESS 1701 Laurens St.			



FUNERAL DIRECTOR: IMPORTANT

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69 0941		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		69 0941	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>BLANCHE BRADLEY</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH <b>Jan 24 1969 3:45 P.M.</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>U. of Maryland Hospital Redwood &amp; Greene Sts.</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>4-02</b>			
5. SEX <b>F</b> 6. RACE <b>N</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				C. CITY OR TOWN <b>BALTO</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>				8. DATE OF BIRTH <b>5-9-99</b>		9. AGE (In years last birthday) <b>69</b>	
10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign) <b>TARboro, N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Smith</b>				14. MOTHER'S MAIDEN NAME <b>Susan Smith</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>212-18-0540</b>		17. INFORMANT <b>Mr. Ervin Pitts</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>5-69-9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CARDIAC ARREST</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>HYPOVOLEMIA</b> <b>G.I. BLEEDING</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>NONE</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sec.</b> <b>17 hrs.</b> <b>24 hrs.</b>			
19A. DATE OF OPERATION <b>Jan 24 1969</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>G.I. Bleeding</b>		20A. AUTOPSY? (Yes or No)		20B. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NONE</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>NONE</b>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <del>the</del> (this hospital) attended the deceased from <b>Jan 24 1969</b> to <b>Jan 24 1969</b> that <del>he</del> (we) last saw the deceased alive on <b>Jan 24 1969</b> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>He</del> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Joseph Orlando</b>						23B. DATE SIGNED <b>Jan 24 69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Joseph Orlando</b>		23D. ADDRESS <b>U. of Md. Hospital Md.</b>		23E. FUNERAL DIRECTOR <b>Morton &amp; Dyett F. H.</b>		ADDRESS <b>1701 Laurens St</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-28-69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Arbutus M. Park</b>		24D. LOCATION (City, town, & county) (State) <b>Baltimore City</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>9590000</b>		25C. FUNERAL DIRECTOR <b>Morton &amp; Dyett F. H.</b>		ADDRESS <b>1701 Laurens St</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

WILLIAM GREEN

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

1

25

69

9:40 a.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION (If not in hospital or institution, give street  
address or location)

Lutheran Hospital D.O.A.

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

January 25, 1969 9:40 a.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

Male

7. RACE

Colored

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

1-15-48

10. AGE (In years  
last birthday)

21

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1106 Monroe St.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Leroy Green

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Unknown

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Ethel Green

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Ethel Green 1106 N. Monroe Street

19. E929X

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Fractured neck C4  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF:

(C) \_\_\_\_\_

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

Unknown

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Unknown

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.) ? ? ? ? m.22E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Unknown

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/26/69

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1-29-69

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn

24D. LOCATION

(City, town, or county)

(State)

Baltimore City

25A. DATE REC'D BY HEALTH DEPT.

JAN 27 1969

25B. NAME OF REGISTRAR

Robert E. Finkbeiner

25C. FUNERAL DIRECTOR

Morton &amp; Dyett F. H. 1701 Laurens St.

ADDRESS

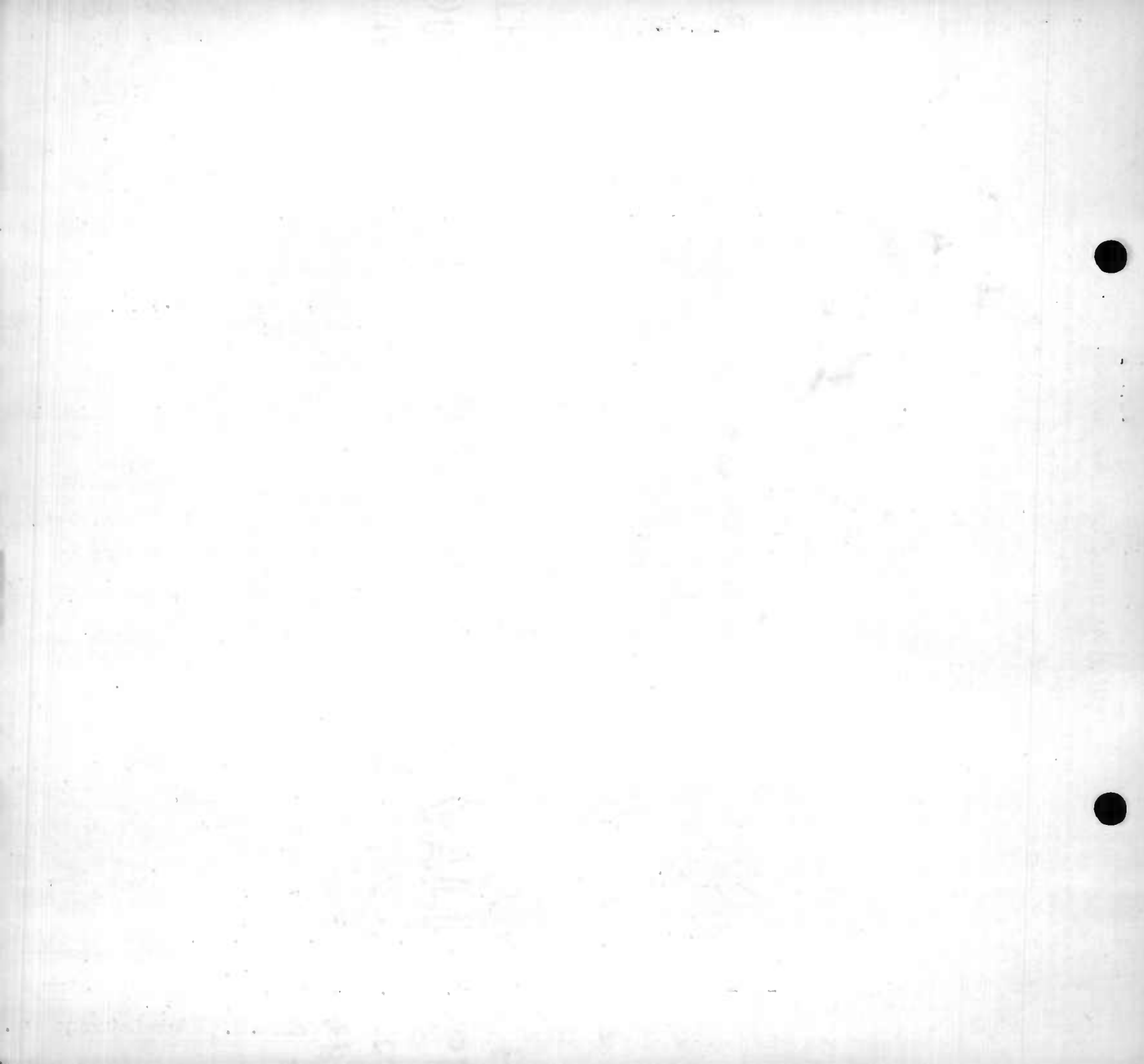


10/1/51

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		SYLENIOUS JEFFRESS		1/22/69 7:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVE. BALTO. MD. 21224				A. STATE MARYLAND B. COUNTY BALTIMORE	
5. SEX MALE				6. RACE NEGRO	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 6-6-23	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic				11. BIRTHPLACE (State or foreign country) NORTH CAROLINA, Person	
13. FATHER'S NAME JUNE JEFFRESS				14. MOTHER'S MAIDEN NAME SUSANNA GILMORE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.				16. SOCIAL SECURITY NO. 224-22-5969	
17. INFORMANT BCH: RECORDS 4940 EASTERN AVE. BALTO. MD.				ADDRESS 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (1) SEPTICEMIA (2) BILATERAL SUBDURAL HEMATOMA (3) BASILAR + RT. PARIETAL SKULL FRACTURE (B) DUE TO, OR AS A CONSEQUENCE OF: (4) LOW PRESSURE HYDROCEPHALUS (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0 DAYS 6 MONTHS 4 MONTHS 4 MONTHS 4 MONTHS	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II RECURRITUS ULCER, LT HIP				9 WKS	
19A. DATE OF OPERATION 10/31/68 11/29/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED SUBDURAL HEMATOMA VENTRICULAR-PERITONEAL SHUNT		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1605 HOMESTEAD ST.	
21D. TIME OF INJURY (APPROX.) 9 30 68 3:00 PM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? PROBABLE FALL DOWN STAIRS	
22. I certify that (I) (this hospital) attended the deceased from 10-28-68 to 1-22-69, that (I) (we) last saw the deceased alive on 1-22-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23B. DATE SIGNED 1/22/69	
23A. SIGNATURE JOSEPH KAPLAN M.D.				23C. PHYSICIAN'S NAME (Type) JOSEPH KAPLAN M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-28-69		24C. NAME OF CEMETERY or CREMATORY Chestnut Grove Ch. Cem.	
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1969		25B. NAME OF REGISTRAR J. E. S. S.		25C. FUNERAL DIRECTOR MORTON & BYETT F.H.	
24D. LOCATION (City, town, or county) Senora,		24E. LOCATION (State) North Carolina		ADDRESS 1701 Laurens St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

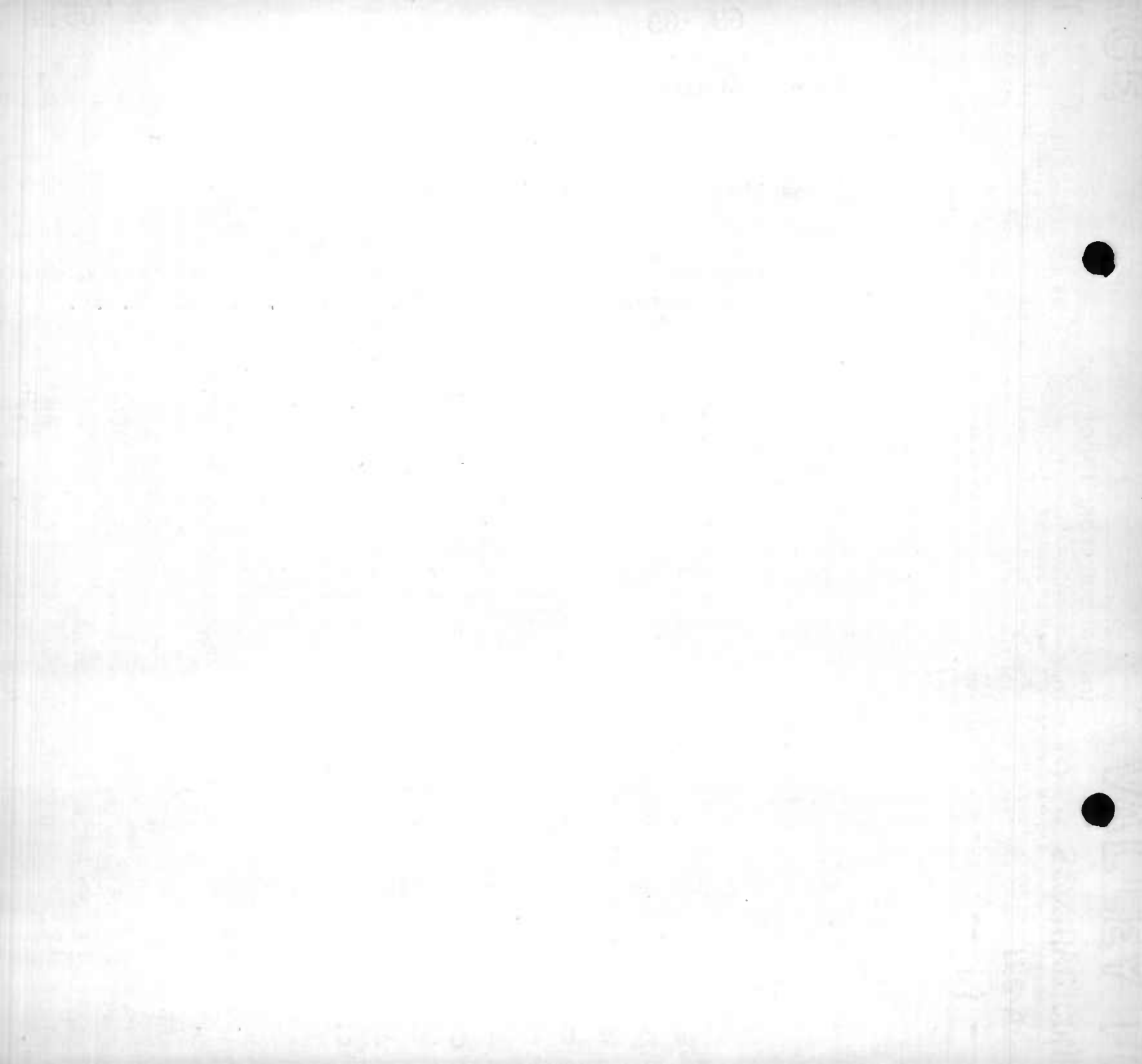
69 0944

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

69 0944

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Ann Green</i>		2. DATE AND HOUR OF DEATH <i>1/24/69 8:32 A M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Sinai Hospital</i>			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>15-13</i>		
5. SEX <i>F</i>			6. RACE <i>C</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>2-9-44</i>		9. AGE (In years last birthday) <i>24</i>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machine Operator</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Western Electric</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			13. FATHER'S NAME <i>John W. Mackel</i>		
14. MOTHER'S MAIDEN NAME <i>Anna Mackel</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No.</i>		
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Charles E. Green 2400 Loyola Northwa</i>			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute Pulmonary Edema</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>hours</i>	
		(B) <i>Systemic lupus Erythematosus</i> DUE TO, OR AS A CONSEQUENCE OF:		<i>4 months</i>	
		(C) <i>lupus nephritis</i>		<i>4 months</i>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <i>10/15</i> 19 <i>68</i> to <i>1/24</i> 19 <i>69</i> , that (I) <del>we</del> lost saw the deceased alive on <i>1/23</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Howard R. Friedman M.D.</i>				23B. DATE SIGNED <i>1/24/69</i>	
23C. PHYSICIAN'S NAME (Type) <i>Howard R. Friedman M.D.</i>				23D. ADDRESS <i>Sinai Hosp of Balto, Md.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-28-69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore National</i>	
24D. LOCATION <i>Balto, City</i>		24E. DATE REC'D BY HEALTH DEPT. <i>JAN 27 1969</i>			
24F. NAME OF REGISTRAR <i>Robert E. [illegible]</i>		24G. FUNERAL DIRECTOR <i>Morton &amp; Dyett F. H. 1701 Laurens St.</i>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO. 18-21751

## 1. NAME OF DECEASED

(Type or Print)

LAWRENCE NATHANIEL HALL

## 2. DATE OF DEATH

Known ☐ Estimated ☐

Month Day Year January 24, 1969

Hour Minute 2:10 A. M.

## 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

SINAI HOSPITAL (DOA)

## 3. DATE PRONOUNCED DEAD

Month Day Year January 24, 1969

Hour Minute 2:10 A. M.

## 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

27-65

## 6. SEX

Male

## 7. RACE

Negro

B. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

## C. CITY OR TOWN

Baltimore

## D. INSIDE CITY LIMITS?

YES ☒NO ☐

## 9. DATE OF BIRTH

11-13-1968

## 10. AGE (In years last birthday)

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. 2

## E. STREET AND NUMBER

2010 W. Cold Spring Avenue

## 11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

Lawrence Nathaniel Hall, Sr.

## 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Infant

## 14B. KIND OF BUSINESS OR INDUSTRY

## 15. MOTHER'S MAIDEN NAME

Sharon Harrison

## 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No.

## 17. SOCIAL SECURITY NO.

-0-

## 18. INFORMANT

Mr. Lawrence Hall, Sr.

## ADDRESS

Same

## 19.

## DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

## CAUSE OF DEATH

Interstitial pneumonitis (SDII)

## (A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

## (B)

DUE TO, OR AS A CONSEQUENCE OF:

## (C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

## II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

## 20A. DATE OF OPERATION

## 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

## 21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

## 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

## 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

## 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

## 22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

## 22F. HOW DID INJURY OCCUR?

## 23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/24/69

## 24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

## 24B. DATE

1-27-69

## 24C. NAME OF CEMETERY or CREMATORY

Arbutus Mem. Park

## 24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

## 25A. DATE REC'D BY HEALTH DEPT.

JAN 27 1969

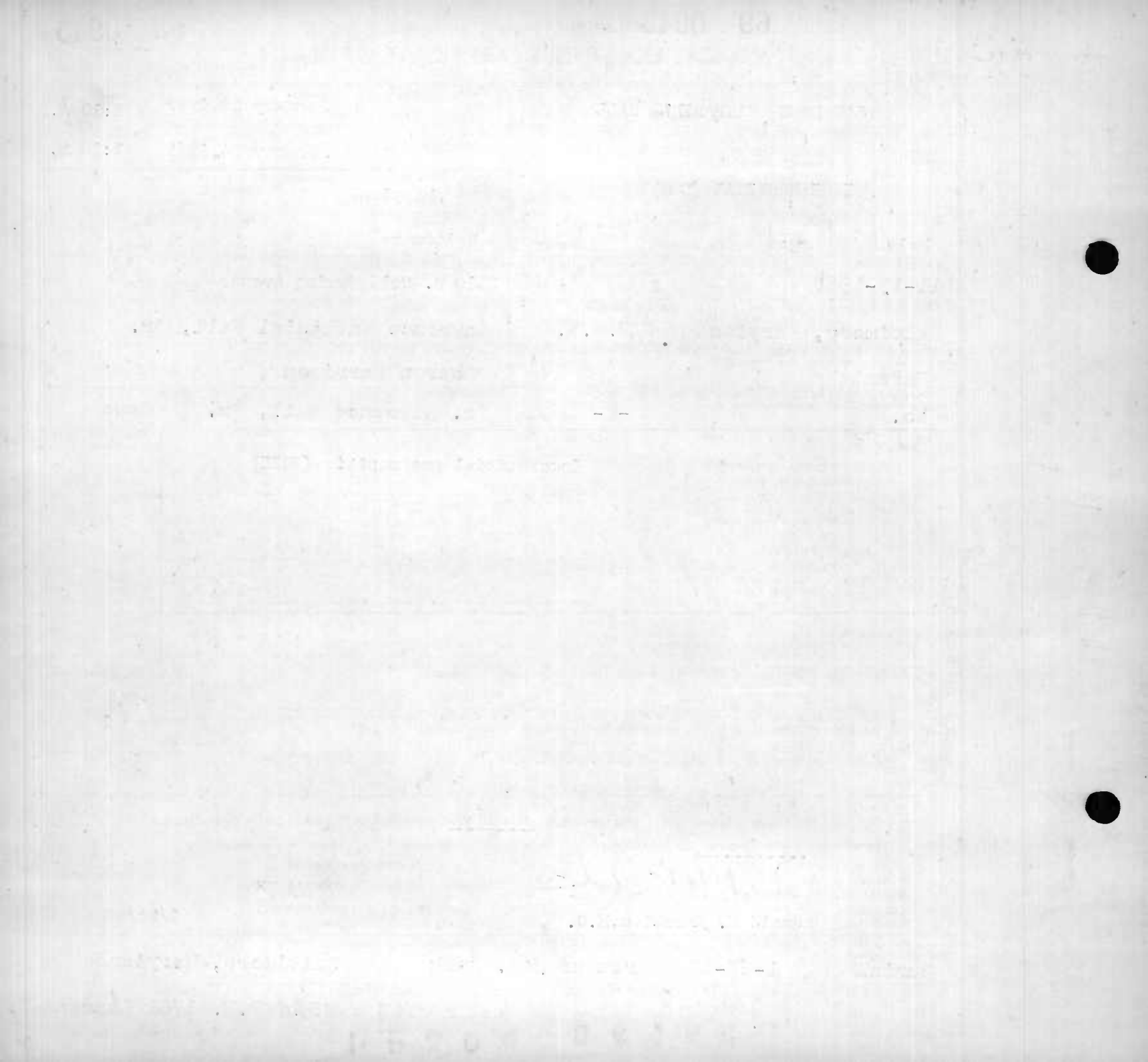
## 25B. NAME OF REGISTRAR

Robert E. Tarkenton

## 25C. FUNERAL DIRECTOR

MORTON &amp; DYETT F.H. 1701 Laurens St

## ADDRESS



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 0946 REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN Quickley

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

1 25 69

1:25 p. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

City Hospital

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

January 25, 1969 1:25 p. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

6. SEX

7. RACE

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Male

Colored

Balto.

YES ☒ NO ☐

9. DATE OF BIRTH

10-4-31

10. AGE (In years  
last birthday)

37

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

4505 Roakly Rd.

11. BIRTHPLACE (State or foreign country)

Balto., Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John W. Quickley, Sr.

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

Charles Center

15. MOTHER'S MAIDEN NAME

Evelyn H. Glascoe

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No.

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Dorothy Quickley 4505 Rokeby Road

19. E812.0

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Craniocerebral injuries  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

Street

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Erdman Ave. 226 ft. N. of Old Pt. Rd.

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

1

25

69

11:05

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Driver of auto-auto collision

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/26/69

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1-28-69

24C. NAME of CEMETERY or CREMATORY

Arbutus Mem. Park

24D. LOCATION (City, town, or county) (State)

Baltimore County

25A. DATE REC'D BY HEALTH DEPT.

JAN 27 1969

25B. NAME OF REGISTRAR

Robert E. Seabury

25C. FUNERAL DIRECTOR

Morton &amp; Dyett F. Balto, Md.

ADDRESS

1701 Laurens St. Balto, Md.

Robert M. Knapp

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 0947

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

BERNIE (Burnie) MARTIN

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

January 19, 1969

1:30 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Mercy Hospital

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

January 19, 1969

1:30 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

12-05

6. SEX

male

7. RACE

negro

B. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Sept 26, 1917

10. AGE (In years  
last birthday)

46-50

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

423 E. North Avenue

11. BIRTHPLACE (State or foreign country)

S.C.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

15. MOTHER'S MAIDEN NAME

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

World War 2

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Ella Mae Martin 1007 McDougall St

19. 2-9631 X

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Gunshot Wound to Head

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

street

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

1300 Proctor St.

9-09

22D. TIME (Month) (Day) (Year) (Hr.) (Min.)  
OF INJURY (APPROX.)

1/18/69 10:15

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

subj. shot by un-

known assailants

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/19/69

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

Jan 24/69

24C. NAME OF CEMETERY OR CREMATORY

Baldwin Cemetery

24D. LOCATION (City, town, or county)

Westport Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 21 1969

25B. NAME OF REGISTRAR

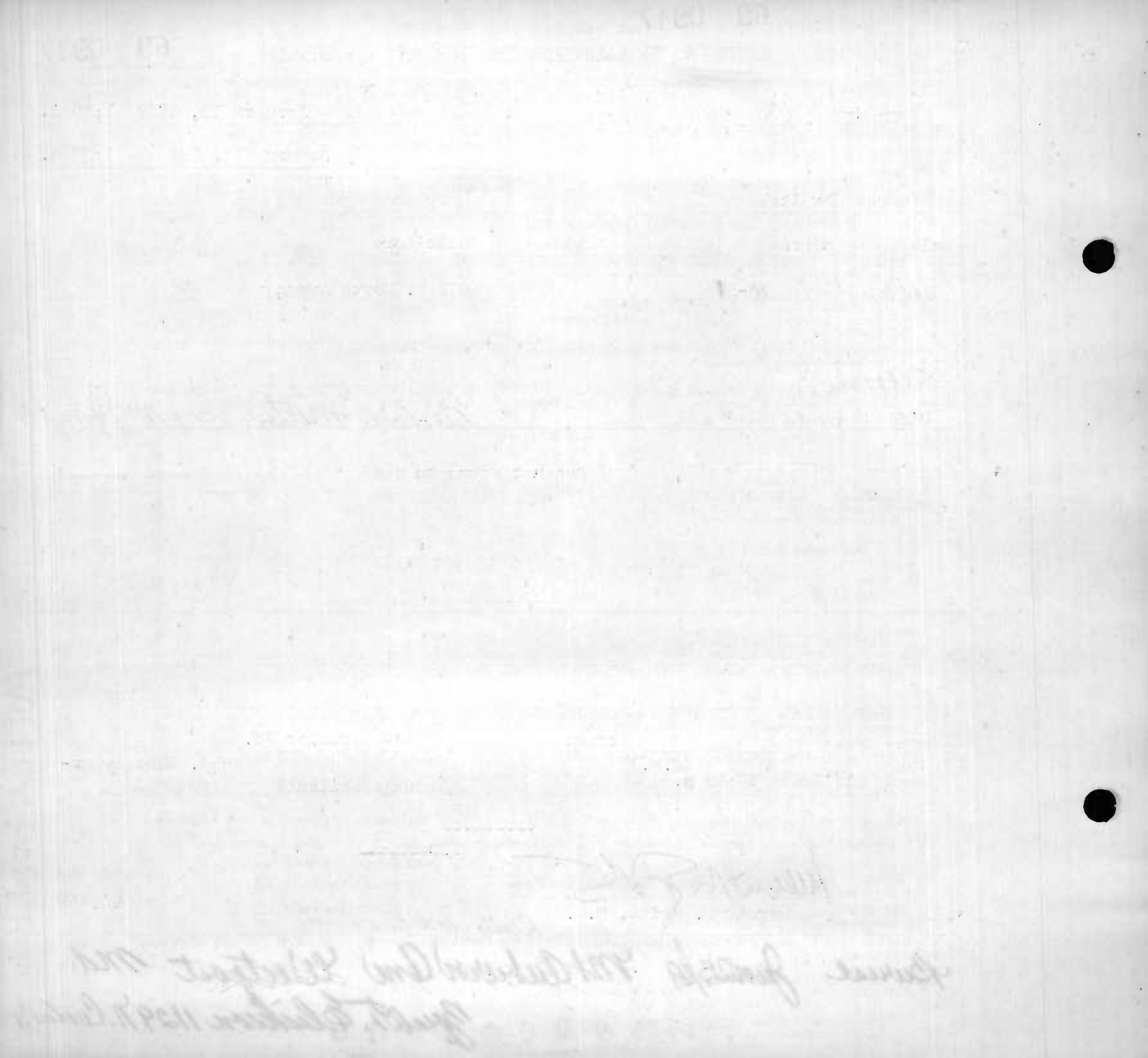
J. J. Johnson

25C. FUNERAL DIRECTOR

J. J. Johnson

ADDRESS

11297 N. Charles St





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0948 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 69 0948

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>THOMPSON, <del>CLARA</del> ANN</b>		2. DATE AND HOUR OF DEATH <b>26 January, 1969 11<sup>05</sup> A M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>8-33</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>FEMALE</b>		6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-14-23</b>	9. AGE (In years last birthday) <b>45</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Va.</b>	
13. FATHER'S NAME <b>ROBERT DRUMMOND</b>			14. MOTHER'S MAIDEN NAME <b>LOTTIE JONES</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Theodore Thompson</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>174X I</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Respiratory Arrest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <b>Pneumonia - Relapsant</b> DUE TO, OR AS A CONSEQUENCE OF: <b>36 hours</b>		(?) <b>Pulmonary embolus</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			(C) <b>Obstruction 2° breast cancer metastatic to brain</b> <b>3 mos</b>		
19A. DATE OF OPERATION <b>7/1/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>lobular carcinoma of the breast</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <b>15 November 1968</b> to <b>26 January 1969</b> , that (I) <del>we</del> last saw the deceased alive on <b>25 January 1969</b> and that (in <del>my</del> ) (our) opinion death occurred on the date and hour and from the causes stated above. <del>He</del> (We) (did) <del>not</del> view the body after death.					
23A. SIGNATURE <b>Paul L. Tecklenberg</b>			23B. DATE SIGNED <b>26 January 1969</b>		
23C. PHYSICIAN'S NAME (Type) <b>PAUL L. Tecklenberg MD.</b>			23D. ADDRESS <b>110 601 N. Broadway, 1169 Baltimore, Md. 21205</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE		24C. NAME OF CEMETERY or CREMATORY <b>La Crosse Va.</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>John P. Elicker</b>		25C. FUNERAL DIRECTOR <b>1129 D. Carver St</b>	

~~SECRET~~

*Handwritten signature*

*Handwritten text at bottom left*

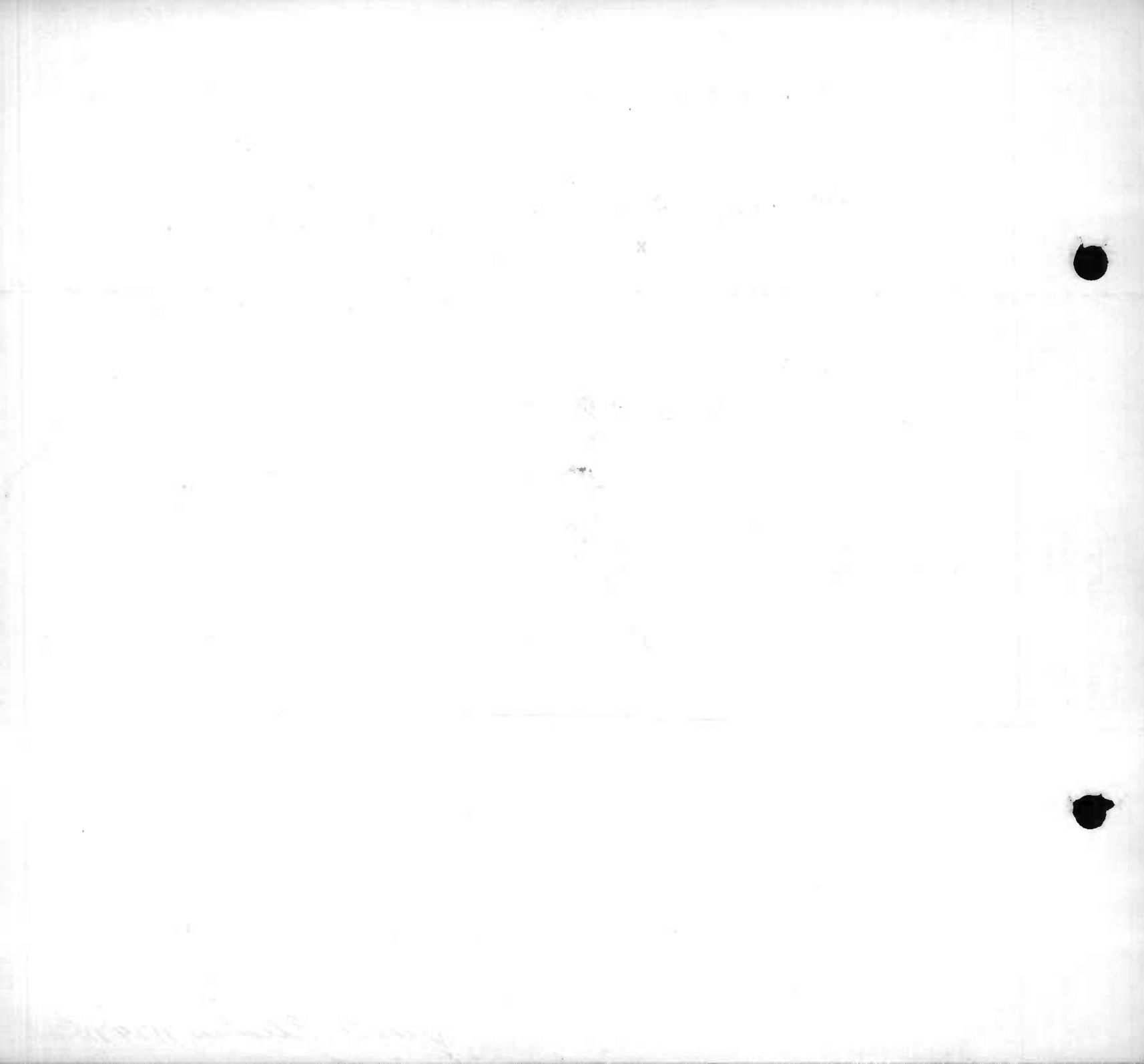
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0949 BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 0949

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		REV. ISAAC WILLIAMS		January 17, 1969 2:55 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE	
33 JOHNS HOPKINS HOSPITAL 601 N. BROADWAY BALTIMORE, MARYLAND 21205				B. COUNTY MARYLAND	
				C. CITY OR TOWN	
				D. INSIDE CITY LIMITS?	
				E. STREET AND NUMBER	
				3601 FOREST PARK AVE. 15-38	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MALE	NEGRO	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2/22/23	45	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Fayette County West Va.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
SAMUEL WILLIAMS			JULIA REDD		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
Yes World War II			236 22 3333		ADDRESS
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Jan Dec 27 19 68 to Jan 17 19 69					
that (I) (we) last saw the deceased alive on January 17 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
WM. MacDONALD				January 17, 1969	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
WM. MacDONALD				THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		Jan 23/69		Arbutus Memorial	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 27 1969		J. E. Egan		Z. E. Egan	
				ADDRESS	
				1129 N. Calhoun	



131 17 57 R  
KING, YOUNG

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-520 69 0950 BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 0950	
BIRTH NO.				1	
1. NAME OF DECEASED (Type or Print)		YOUNG KING		2. DATE AND HOUR OF DEATH 3:10 AM 1/21/69 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 27-59	
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE	
5. SEX MALE		6. RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CUSTODIAN		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 9-14-91	
13. FATHER'S NAME RICHARD KING		14. MOTHER'S MAIDEN NAME LIZZIE		9. AGE (in years last birthday) 77	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII 1941-1945		16. SOCIAL SECURITY NO. 212-22-9608		11. BIRTHPLACE (State or foreign country) Thomas, Ga.	
17. INFORMANT ANNA MARTIN		ADDRESS 4417 THE ALAMEDA		12. CITIZEN OF WHAT COUNTRY? 69	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Respiratory insufficiency Sepsis Pneumonia, post op state ASCVD				1 WK 1 WK	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II ASCVD					
19A. DATE OF OPERATION 3-1-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED GT bleeding		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) No		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/21/69 to 1/21/69 that (I) (we) last saw the deceased alive on 1/21/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE R Katz MD		23B. DATE SIGNED 1/21/69		23C. PHYSICIAN'S NAME (Type) RICHARD KATZ M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-24-69		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park	
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1969		25B. NAME OF REGISTRAR M. J. S. S. S.		25C. FUNERAL DIRECTOR M. J. S. S. S.	
24D. LOCATION (City, town, or county) Arbutus Md.		24E. LOCATION (City, town, or county) Arbutus Md.		24F. LOCATION (City, town, or county) N. C. FOLK	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 0951

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

EDWARD

TILLERY

2. DATE  
OF DEATHKnown ☐ Estimated ☒

Month

Day

Year

Hour

January 15, 1969

UNK

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

(If not in hospital or institution, give street  
address or location)

1711 Harford Avenue

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

January 18, 1969

12 noon M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

male

7. RACE

negro

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☒

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

May 17, 1931

10. AGE (In years  
last birthday)

38

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1711 Harford Avenue

11. BIRTHPLACE (State or foreign country)

Guernsey.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Robert Tillery

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Mamie Smith

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

18. INFORMANT

Mamie Smith 770 W. Annapolis

ADDRESS

19.

3-71-8

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Fatty Metamorphosis of the Liver

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT  
m. WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

-M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/19/69

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial Jan 27 1969

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cem

24D. LOCATION (City, town, or county)

Westport Md

25A. DATE REC'D BY HEALTH DEPT.

JAN 27 1969

25B. NAME OF REGISTRAR

Robert E. Spitz

25C. FUNERAL DIRECTOR

Frank W. Elukow 1129 N. Calver

ADDRESS

James Smith  
James Smith  
James Smith

James Smith  
James Smith

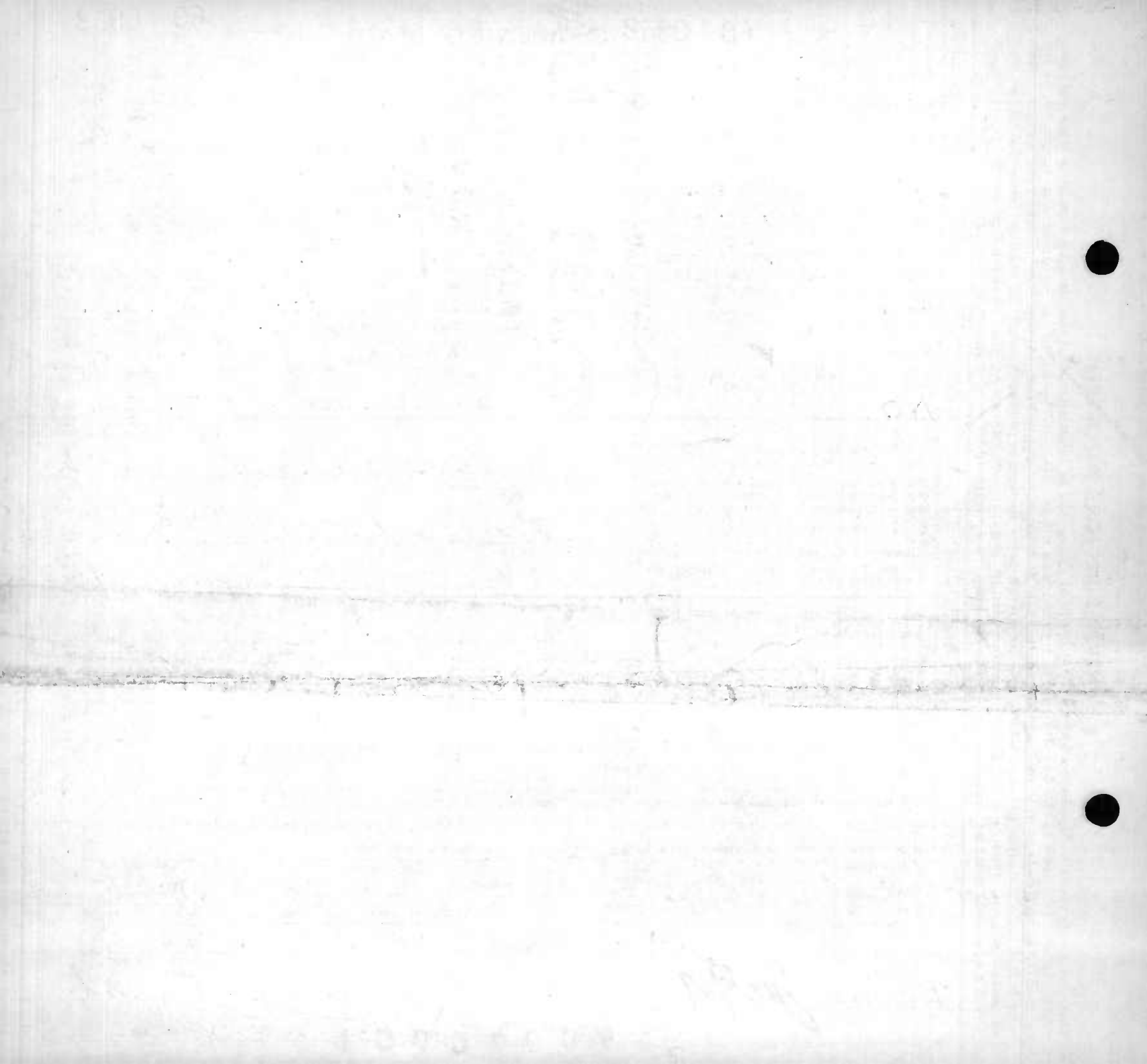
James Smith  
James Smith  
James Smith



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		69 0952		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 0952	
1. NAME OF DECEASED (Type or Print) <b>JOHNNIE ROBERSON</b>				2. DATE AND HOUR OF DEATH <b>JAN 17 '69 1 30 P M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>8-06</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVE.</b> <b>BALTIMORE, MD. 21224</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>1524 N. WOLFE 21213</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-28-15</b>		9. AGE (In years last birthday) <b>53</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNEMPLOYED</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>LEXINGTON U. S. A.</b>	
13. FATHER'S NAME <b>LOUIS</b>				14. MOTHER'S MAIDEN NAME <b>EMMA ROMAN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>BCH RECORDS: 4940 EASTERN AVE. 21224</b>			
18. <b>440.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>EXSANGUINATION</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 h</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>LEAKING AORTO FEMORAL BYPASS 6 weeks</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>SEVERE ARTERIO SCLEROSIS YEARS</b> (C) <b>INFECTED GRFT</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>D</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <del>(I)</del> <b>(this hospital)</b> attended the deceased from <b>DEC 3 1969</b> to <b>JAN 17 1969</b> , that <del>(I)</del> <b>(we)</b> last saw the deceased alive on <b>JAN 17 1969</b> and that in <del>(my)</del> <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. <del>(I)</del> <b>(We)</b> <del>(did)</del> <b>(did not)</b> view the body after death.							
23A. SIGNATURE <b>Rolf H. Bessin</b>				23B. DATE SIGNED <b>JAN 17 '69</b>		23C. PHYSICIAN'S NAME (Type) <b>ROLF H. BESSIN</b>	
				23D. ADDRESS <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVE. 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>3/1/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>MT. KUBURN CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>WESTPORT, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>2-1-1969</b>		25B. NAME OF REGISTRAR <b>Robert S. Fairbanks</b>		25C. FUNERAL DIRECTOR <b>William E. Erickson</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 69 0953 CERTIFICATE OF DEATH

REG. NO. 69 0953

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Lamb, Charles Robert		1/23/69 2:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				Ohio	
The Johns Hopkins Hospital				C. CITY OR TOWN Bucyrus	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 906 S. East Street	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. Under 1 Yr. Months Days
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9/15/03	65	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Proprietor		Interior Decorator		Bucyrus, Ohio	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Robert W. Lamb			Ida Kate Diller		
15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Bucyrus, Ohio Wise Funeral Home, 129 W. Warren St.	
18. 412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE Atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF: with Coronary insufficiency (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				Since peripheral vascular disease	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/22 1969 to 1/23 1969, that (I) (we) lost saw the deceased alive on 1/23 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Marvin C. Mengel M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Marvin C. Mengel, M.D.				The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Rem-Burial		1/27/69		Oakwood	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 27 1969		Robert E. Stedman		H. W. Jenkins & Sons Co. 4905 York Rd. Balto. Md. 21212	

Amount paid for

rent

for the year

1880-81

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 69 0954 CERTIFICATE OF DEATH

REG. NO. 69 0954

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JOHN B. DOYLE</b>		2. DATE AND HOUR OF DEATH <b>JANUARY 24/1969 1245 A M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>16-05</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL Hospital</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>2300 RIGGS AVENUE</b>					
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/6/1888</b>	9. AGE (In years last birthday) <b>80</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MAINTENANCE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>PUBLIC SCHOOLS</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>			13. FATHER'S NAME <b>John J. Doyle</b>		
14. MOTHER'S MAIDEN NAME <b>Margaret D. Burns</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>215-241859</b>			17. INFORMANT <b>MRS. BENEDICT J. FREDERICK BAUM MD</b>		
18. <b>7369 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>respiratory arrest</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1245 1/24/69</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Y.S</b>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>respiratory arrest</b>		
			(B) <b>Cerebrovascular accident</b> DUE TO, OR AS A CONSEQUENCE OF: <b>12/26/68</b>		
			(C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Y.S</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>December 26 1968</b> to <b>January 24 1969</b> , that (I) (we) last saw the deceased alive on <b>January 24 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ernie Allen MD</b>				23B. DATE SIGNED <b>1/24/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Ernie Allen MD</b>				23D. ADDRESS <b>Union Memorial Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-27-69</b>		24C. NAME of CEMETERY or CREMATORY <b>Druid Ridge</b>	
24D. LOCATION <b>Pikesville Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>			
25B. NAME OF REGISTRAR <b>995 9 0 3 3</b>		25C. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co. 4905 York Rd.</b>			

24

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 69 0955 CERTIFICATE OF DEATH

REG. NO.

69 0955

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Frederick H.C. Hancock

2. DATE AND HOUR OF DEATH

1/23/69 9:45 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

44 Union Memorial Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

Md. Balt. 27-78

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

5415 Lothian Rd.

5. SEX

M

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

7/26/02

9. AGE (In years last birthday)

66

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired - Dept. Mgr.

10B. KIND OF BUSINESS OR INDUSTRY

Hochschild Kohn & Co.

11. BIRTHPLACE (State or foreign country)

Scotland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Frederick Hancock Sr.

14. MOTHER'S MAIDEN NAME

Mary Campbell

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II

16. SOCIAL SECURITY NO.

133-10-9170

17. INFORMANT

Hugh F. Hancock, 3 Farwell Court

ADDRESS

21236

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) Congestive Heart Failure  
DUE TO, OR AS A CONSEQUENCE OF:

(C).....

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 11 1969 to Jan 23 1969, that (I) (we) lost saw the deceased alive on Jan 23 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Dr. Charles R. Goshen

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1/23/69

23C. PHYSICIAN'S NAME (Type)

Dr. Charles R. Goshen

23D. ADDRESS

Union Memorial Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

Cremation

24B. DATE

1/24/69

24C. NAME OF CEMETERY or CREMATORY

Greenmount

24D. LOCATION

Baltimore,

(City, town, or county)

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 27 1969

25B. NAME OF REGISTRAR

Charles R. Goshen

25C. FUNERAL DIRECTOR

H. J. Jenkins & Sons Co.

ADDRESS

4905 York Rd. Baltimore, 12, Md.



Walter D. Smith

Walter D. Smith



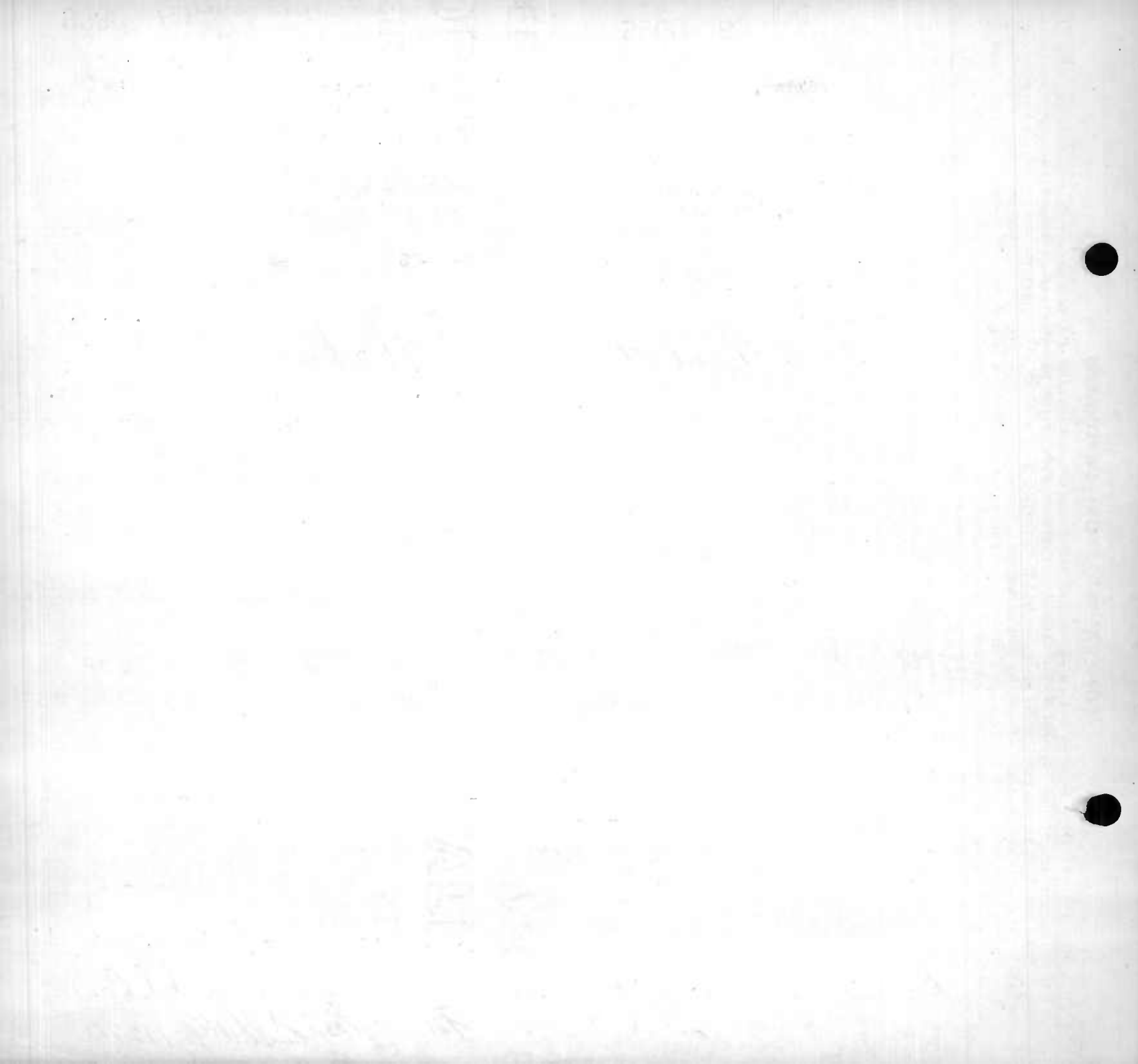
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0956 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 69 0956

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Miller, Ruth</b>		2. DATE AND HOUR OF DEATH <b>1-21-69 4:50 a. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>17-03</b>		C. CITY OR TOWN <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>39 Provident Hospital</b> <b>1514 Division Street</b> <b>Baltimore, Maryland</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>661 Greenwillow Street</b>	
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ? DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-10-03</b>	9. AGE (In years last birthday) <b>65</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>?</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Ben Nesbitt</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service)		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Mrs. Lillian Lewis 1114 Wcalloor Ct.</b>	
18. <b>431.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Hemorrhage</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebral Hemorrhage</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>1-24-69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1-5-69</b> to <b>1-21-69</b> , that (I) (we) last saw the deceased alive on <b>1-21-69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Virginia Y. Fausto, M.D.</b>		23B. DATE SIGNED <b>1-21-69</b>		23C. PHYSICIAN'S NAME (Type) <b>VIRGINIA Y. FAUSTO M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1-24-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Calvary</b>	
24D. LOCATION (City, town, or county) (State) <b>Ann Arundel Co. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. ...</b>	
25C. FUNERAL DIRECTOR <b>Edw. ...</b>		25D. ADDRESS <b>1727 N. ...</b>		25E. ...	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0957

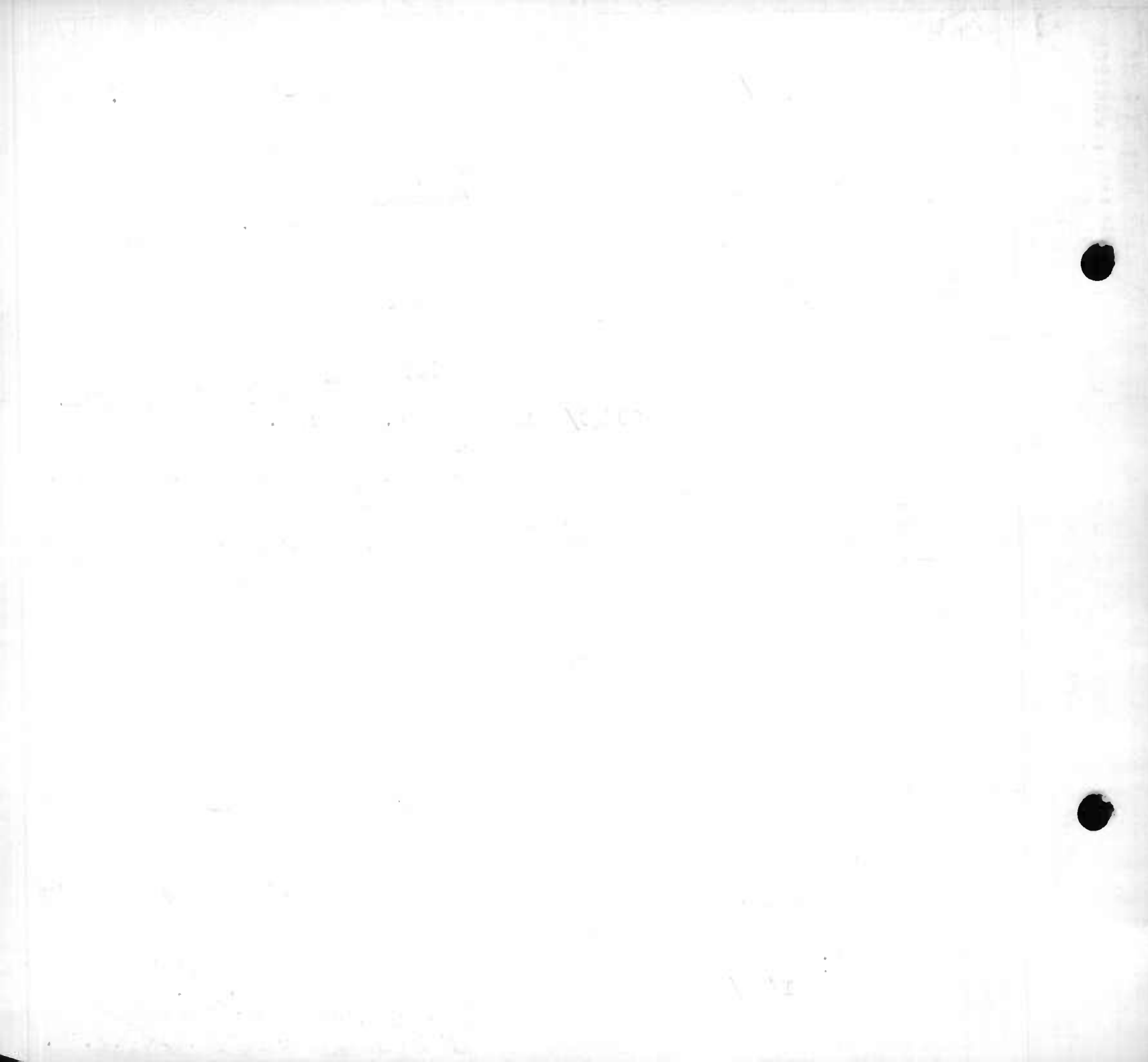
BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

69 0957

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>BUHRMAN</b>		2. DATE AND HOUR OF DEATH <b>1-22-69 3:00 A M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>THE JOHNS HOPKINS HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		C. CITY OR TOWN <b>DUNDALK</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 THE JOHNS HOPKINS HOSPITAL</b>		E. STREET AND NUMBER <b>2529 YORK WAY APT D. 21222</b>		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALES LADY</b>	
5. SEX <b>F</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-2-43</b>	9. AGE (In years last birthday) <b>25</b>	10B. KIND OF BUSINESS OR INDUSTRY <b>RETAIL FOOD</b>
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>KELLER BUHRMAN</b>	
14. MOTHER'S MAIDEN NAME <b>EDITH BOND</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-110-0001</b>	
17. INFORMANT <b>JAMES A. WILKINS.</b>		18. CAUSE OF DEATH <b>Pulmonary candidiasis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b>		20. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Fabry's disease</b>		21. DUE TO, OR AS A CONSEQUENCE OF: <b>?</b>	
22. I certify that (1) (this hospital) attended the deceased from <b>Jan 4 1969</b> to <b>Jan 22 1969</b>		23. I certify that (1) (we) last saw the deceased alive on <b>Jan 22 1969</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.		24. I certify that (1) (we) last saw the deceased alive on <b>Jan 22 1969</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.	
25. DATE REC'D BY HEALTH DEPT. <b>1/25/69</b>		26. NAME OF REGISTRAR <b>ROS OFF JR</b>		27. NAME OF REGISTRAR <b>WALTER BROOKS BRADLEY, DUNDALK, MD.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0958

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 69 0958

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		CARLENA SCHEBEN DASCH		1/29/69 4:24 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. CITY OR TOWN	
31 CITY HOSPITAL		MD. BALTIMORE 21222		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
FEMALE CAUCASUAN				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
SALES LADY		RETAIL		1/20/1903	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		9. AGE (In years lost birthday)	
HOLLAND		USA		66	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
CARL SCHEBEN		JOHANNA BOEREN		NO	
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
212/07/4308		JOSEPH J. DASCH		AS IN # 4 ABOVE	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Massive Intra Cranial Hemorrhage DUE TO, OR AS A CONSEQUENCE OF:  (B) Hypertensive Arterio Sclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		Hours Ten years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 1962 to January 1969, that (I) (we) last saw the deceased alive on January 18, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
W. E. BAERMANN, M.D.		January 23, 1969			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		3401 Dundalk Avenue Baltimore, Md. 21222			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		1/24/69		ST. STANISLAUS	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR'S ADDRESS	
JAN 27 1969		WALTER BRADLEY		DUNDALK, MD.	

Correct info. from BCH Admitting Desk SMN

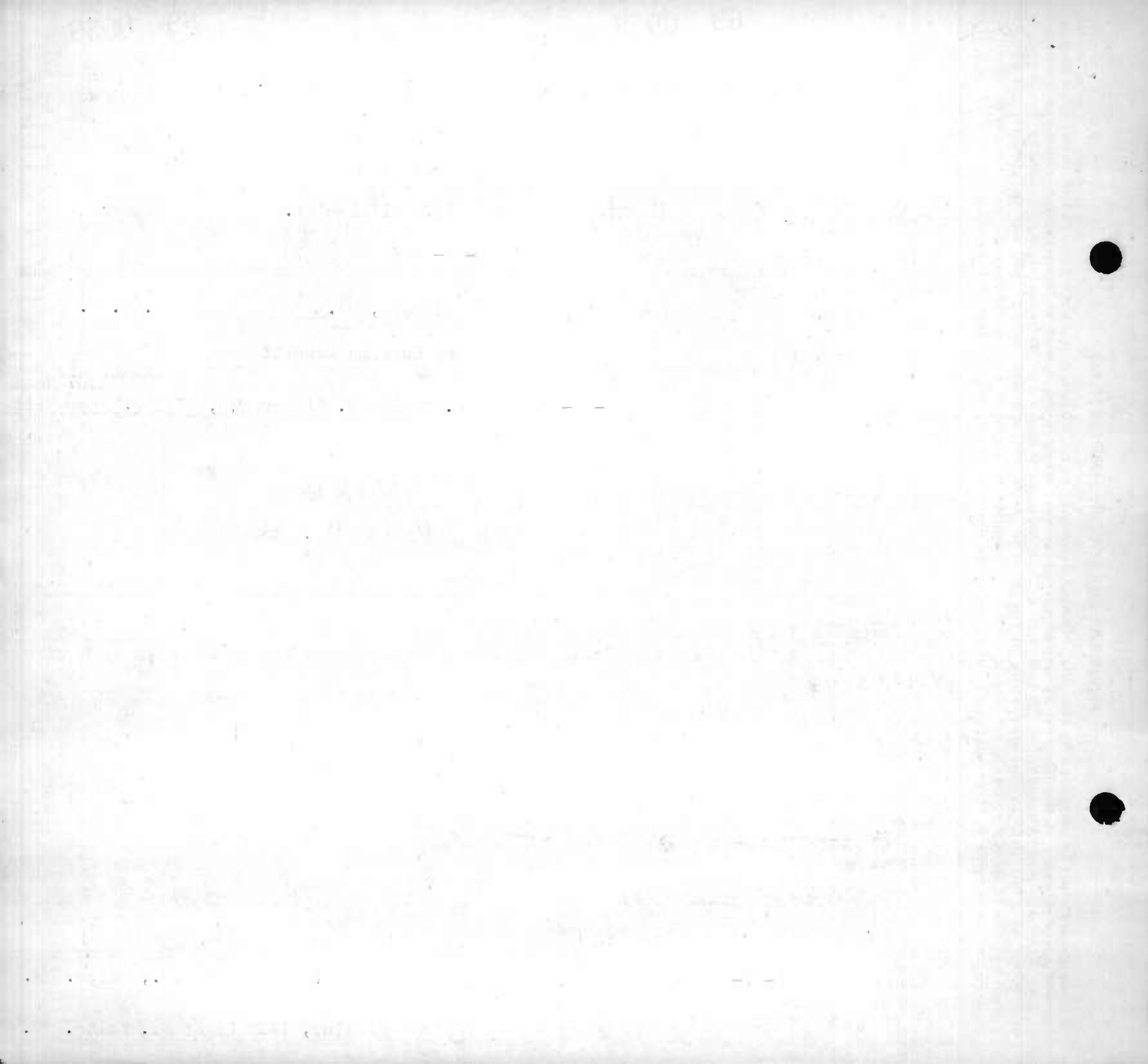
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. **69 0959**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>John R. Streckfus</b>		2. DATE AND HOUR OF DEATH <b>1-24-69 12 <sup>10</sup> pm</b>		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>24-03</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>43 South Baltimore General Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>1279 William St.</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-26-1895</b>	9. AGE (In years lost birthday) <b>73</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watchman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Marsh Market</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Streckfus</b>				14. MOTHER'S MAIDEN NAME <b>Mary Susanna Merritt</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-01-9244</b>		17. INFORMANT ADDRESS <b>21207 Road</b> <b>Mrs. Vaughn E. Richardson, 6715 Windsor Mill</b>			
18. CAUSE OF DEATH							
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, oslhenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.</p> </div> <div style="width: 50%;"> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Aspiration 2° to Sarc</b> <b>GI Bleeding</b></p> <p>(B) <b>Cirrhosis, Portal Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C).....</p> </div> </div>							
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>							
19A. DATE OF OPERATION <b>1-23-69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>abd. separation &amp; Liver Biopsy</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>1</b>		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
<p>22. I certify that <del>(H)</del> (this hospital) attended the deceased from <b>1-10</b> 19<b>69</b> to <b>1-24</b> 19<b>69</b>, that <del>(H)</del> (we) last saw the deceased alive on <b>1-24</b> 19<b>69</b> and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>							
23A. SIGNATURE <b>Stanley R. Weimer, M.D.</b> DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>1-24-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Stanley R. Weimer M.D.</b>		23D. ADDRESS <b>South Baltimore General Hospital</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-27-69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>3801 Frederick Ave., Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Flynn &amp; Fleming, 1422 Light St. Balto. 30.</b>			





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0960

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

69 0960

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

HUNTER JACOB SHINHOLT

2. DATE AND HOUR OF DEATH

JAN 25, 1969 4:55 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

FRANKLIN SQUARE HOSP.

100 N. CALHOUN ST.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

MD. BALTIMORE CITY 23-03

C. CITY OR TOWN

BALTIMORE.

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

1740 LIGHT ST.

5. SEX

M

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

1-22-06

9. AGE (In years  
last birthday)

63

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Court House

10B. KIND OF BUSINESS OR INDUSTRY

GUARD.

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

HUNTER SHINHOLT

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

-

17. INFORMANT

ADDRESS

Mrs. Agnes A. Shinholt 1740 Light St.

18. 4369412509

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION lost.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

CVA

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

- 21 Days

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

DIABETES, PNEUMONIA.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐

Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-4-1969 to 1-25-1969,  
that (I) (we) last saw the deceased alive on 1-25-1969 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Sulan Vongkasemsiri

DEGREE

Attending ☐  
Phys.

Med.  
Director ☐

Staff  
Phys. ☒

23B. DATE SIGNED

JAN 25, 69

23C. PHYSICIAN'S  
NAME (Type)

SULAN VONGKASEMSIRI

DEGREE

23D. ADDRESS

FSTH.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1 28 69

24C. NAME of CEMETERY or CREMATORY

Cedar Hill

24D. LOCATION

(City, town, or county)

(State)

Brooklyn, A. A. C. O. Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 27 1969

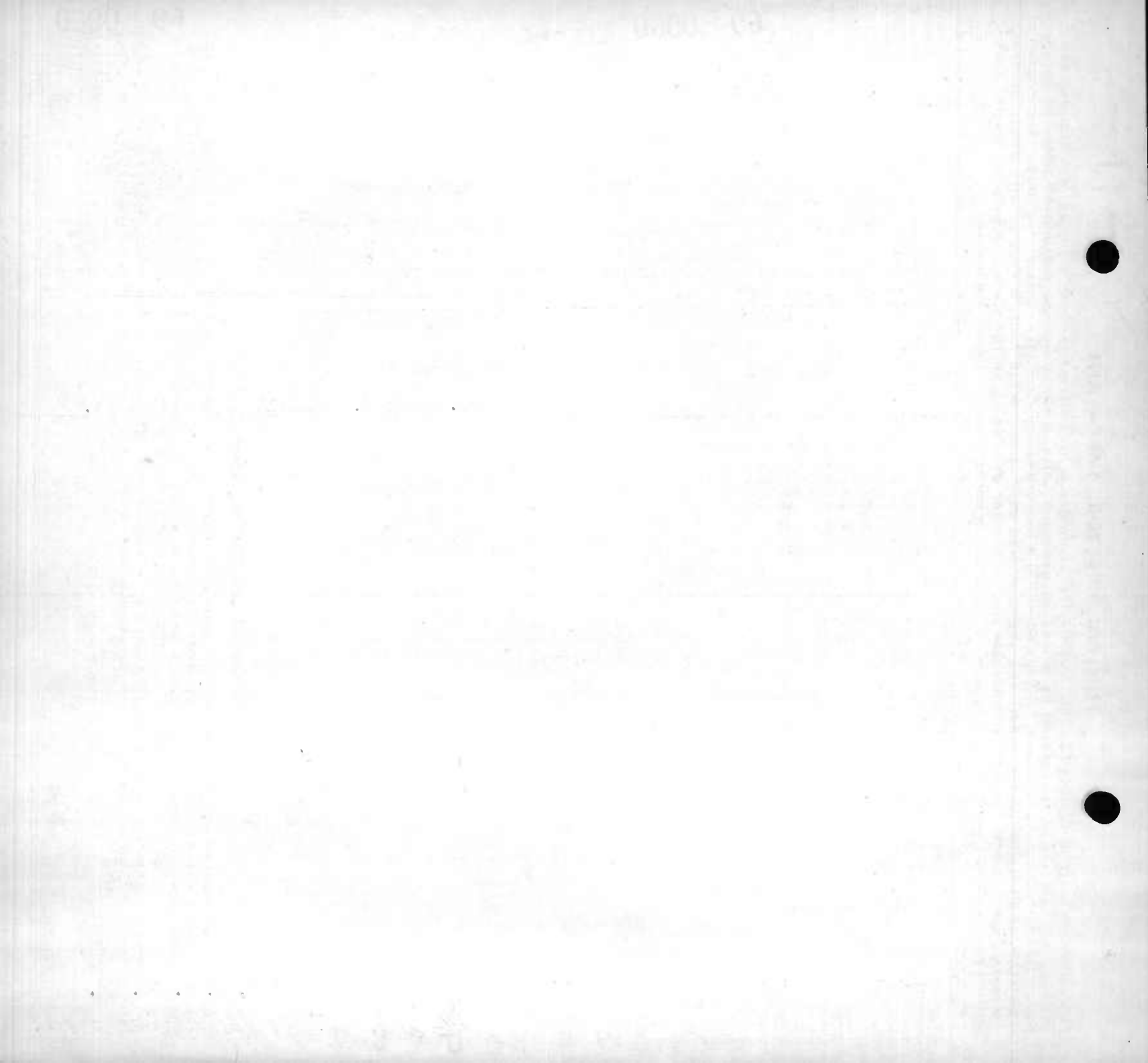
25B. NAME OF REGISTRAR

Robert E. Farber

25C. FUNERAL DIRECTOR

9600 Gully Tunnel Lane 130 Fort Ave.

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. **69 0961**

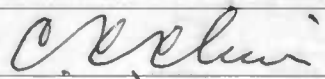
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Leroy C. Greenwell</b>		2. DATE AND HOUR OF DEATH <b>Jan. 23, 1969</b>		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>7034 Surrey Drive</b> <b>00</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>27-20</b>			
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>7034 Surrey Drive</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/17/1893</b>	9. AGE (In years lost birthday) <b>75</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter-Builder</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Self-Employed</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George W. Greenwell</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Wise</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-14-0301</b>		17. INFORMANT ADDRESS <b>Marqueriete (Rudolph) 7034 Surrey Drive</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <b>Cancer of left kidney with metastases</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 mos.</b>	
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>metastases</b>		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Feb. 19, 1968</b> to <b>Jan. 23, 1969</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Jan. 21, 1969</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <b>Marvin Goldstein</b> DEGREE				23B. DATE SIGNED <b>1/25/69</b>			
23C. PHYSICIAN'S NAME (Type) <b>Dr. Marvin Goldstein</b> DEGREE				23D. ADDRESS <b>6001 Park Heights Avenue</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Jan. 27, 69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Druid Ridge</b>		24D. LOCATION (City, town, or county) (State) <b>Pikesville, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>		25B. NAME OF REGISTRAR <b>Robert S. Feiberg</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Loring Byers Chapel 8728 Liberty Road 21133</b>			

1962

WALLACE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">69 0962</span>	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Milton S. Miller Sr.</b>		2. DATE AND HOUR OF DEATH <b>Jan. 24, 1969</b> <span style="float: right;">3:30 A. M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>23-02</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b> <b>1612 Marshall St.</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>1612 Marshall St.</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>July 30, 1905</b>	9. AGE (In years lost birthday) <b>63</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret.- Operator</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Shipyards</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Charles Miller</b>			14. MOTHER'S MAIDEN NAME <b>Sarah ( Hirsch ) Miller</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-03-9488</b>	17. INFORMANT <b>Mrs. Marion Miller</b>		ADDRESS <b>same as # 1</b>
18. <b>41213 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic heart dis.</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <b>General arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF: <b>over 10 yrs</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Acute urinary infection</b>			<b>2 days</b>		
19A. DATE OF OPERATION <b>none</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>---</b>	20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>no.</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>---</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>---</b>	
21D. TIME OF INJURY (APPROX.) <b>---</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>---</b>	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>7-18-</b> <b>19 61</b> to <b>1-24-</b> <b>1969</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>1-23-</b> <b>19 69</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>We</del> ) ( <del>did</del> ) view the body after death.					
23A. SIGNATURE 			23B. DATE SIGNED <b>1-25-69</b>		
23C. PHYSICIAN'S NAME (Type) <b>C. C. Chiu, M. D.</b>			23D. ADDRESS <b>1 E. Randall St. Baltimore Md. 21230</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1-27-'69</b>	24C. NAME of CEMETERY or CREMATORY <b>Cedar Hill Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>McCully-130 E. Fort Ave. 21230</b>	

C. V. Allen

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

69 0963

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>HESSE FLORENCE E.</u>		2. DATE AND HOUR OF DEATH <u>1-26-69</u> <u>6:35 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>SOUTH BALTIMORE GENERAL HOSPITAL</u> <u>43</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>929 HANOVER ST</u>	
S. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-16-85</u>	9. AGE (In years last birthday) <u>83</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> <u>AGNES HARDESTY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JAMES WILSON</u>		14. MOTHER'S MAIDEN NAME <u>AGNES HARDESTY</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-32-9863-A</u>		17. INFORMANT <u>Mr. John A. Hesse Jr. 2202 Eastridge Rd.</u>	
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <u>PULMONARY EDEMA</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CONGESTIVE HEART FAILURE</u>			
		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>			
		(C) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>1-26-69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>1-26-69</u> to <u>1-26-69</u> , that (I) (we) last saw the deceased alive on <u>1-26-69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <u>Marcelino E. Sokongon, M.D.</u> DEGREE	
23B. DATE SIGNED <u>1-26-69</u>		23C. PHYSICIAN'S NAME (Type) <u>MARCELINO E. SOKONGON, M.D.</u> DEGREE		23D. ADDRESS <u>SOUTH BALTIMORE GENERAL HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1 29 69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Glen Haven</u>	
24D. LOCATION (City, town, or county) (State) <u>Glen Burnie, A.A. Co. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 27 1969</u>		25B. NAME OF REGISTRAR <u>John A. Hesse Jr.</u>	
25C. FUNERAL DIRECTOR <u>McCally</u>		25D. ADDRESS <u>2130 East Fort Ave.</u>			

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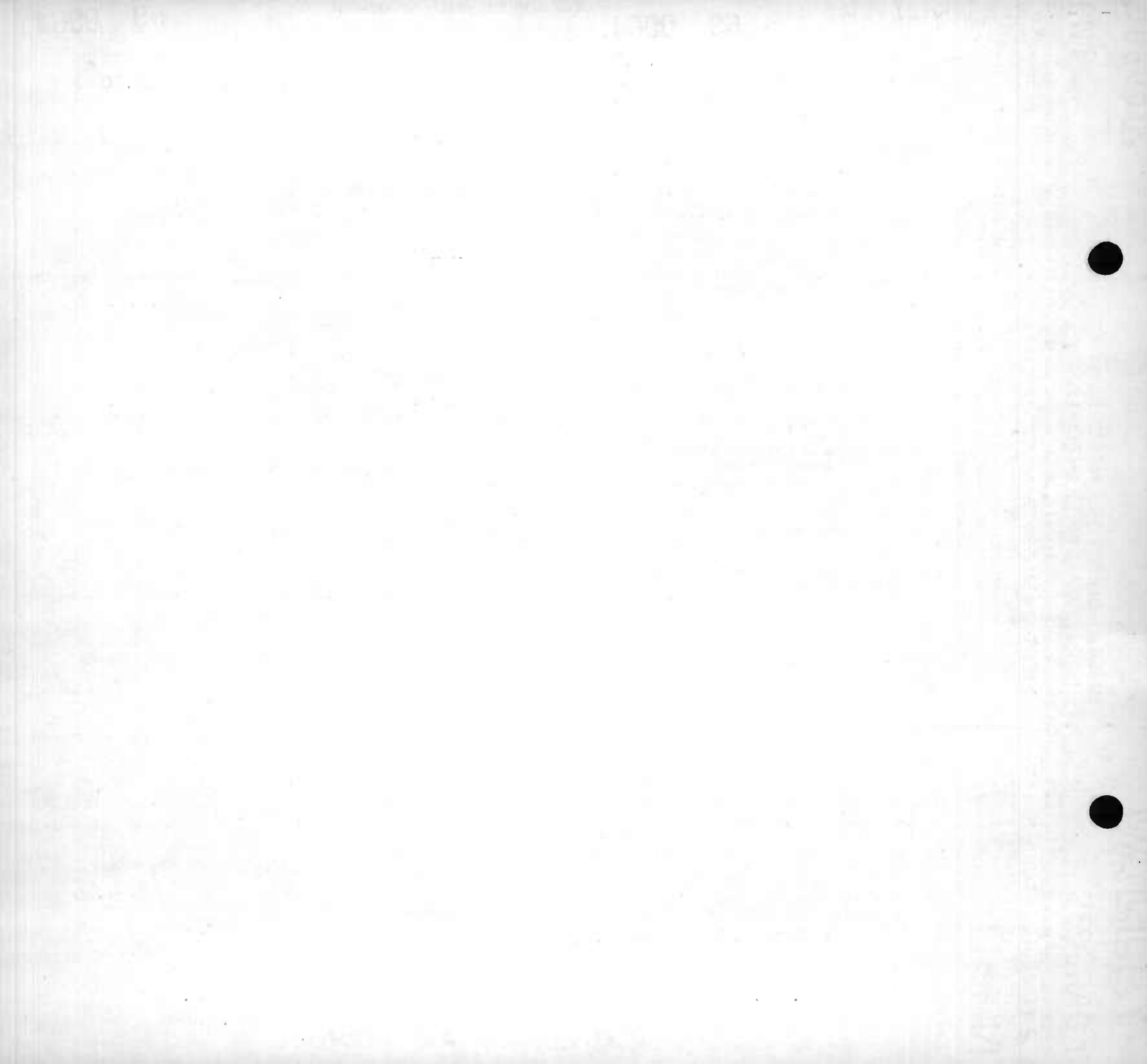
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## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Y-455		69 0964		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 0964	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Ylinen, Matt Vilho</i> (MATT V. YLINEN)			
2. DATE AND HOUR OF DEATH <i>1/23/69</i> 10.10 PM M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>31</i> BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 630 S PONCA STREET #21224							
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-1-24	9. AGE (In years last birthday) 44	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY Wholesale Hardware		11. BIRTHPLACE (State or foreign country) FINLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME VILHO Ylinen				14. MOTHER'S MAIDEN NAME HANNA Pyhalahti			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 220 18 2771		17. INFORMANT ADDRESS RECORDS: BALTIMORE CITY HOSPITALS 4940 EASTERN AVE #21224			
18. <i>34791</i> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiovascular Collapse</i> 2 hrs.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,				(B) <i>Generalized Cerebral Degeneration</i> DUE TO, OR AS A CONSEQUENCE OF:			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notly medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>1/19</i> 19 <i>69</i> to <i>1/23</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>1/23</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Kenneth E. Fligstein MD</i> OEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>1/23/69</i>	
23C. PHYSICIAN'S NAME (Type) KENNETH E FLIGSTEIN M.D. OEGREE				23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVE #21224			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		Jan. 27. 1969		Oak Lawn Cemetery		Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 27 1969</i>		25B. NAME OF REGISTRAR <i>Henry Sander &amp; Sons, Inc.</i>		25C. FUNERAL DIRECTOR <i>Henry Sander &amp; Sons, Inc.</i>		ADDRESS <i>Baltimore Md.</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0965 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 69 0965

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>PIASECKI EDMUND JOHN</b>		2. DATE AND HOUR OF DEATH <b>1/26/69 5<sup>20</sup> A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>UNION MEMORIAL HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>27-48</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNION MEMORIAL HOSPITAL</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>5502 PURDUE AVENUE</b>					
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>03-08-03</b>	9. AGE (In years last birthday) <b>65</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED Book Keeper</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>	12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>
13. FATHER'S NAME <b>MICHAEL PIASECKI</b>			14. MOTHER'S MAIDEN NAME <b>Agnes Hiller</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>255-01-3202</b>		17. INFORMANT <b>ANNE H. PIASECKI</b>	
				ADDRESS <b>SAME ABOVE</b>	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>(A) IMMEDIATE CAUSE CARDIAC ARREST.</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(B) COLON SIGMOID CANCER</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(C) _____</b>					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>_____</b>					
19A. DATE OF OPERATION <b>12/26/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>_____</b>		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>_____</b>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>_____</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>_____</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>_____</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>_____</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>12/26/68</b> 19____ to <b>1/26/69</b> 19____, that (I) (we) last saw the deceased alive on <b>1/26</b> 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) not view the body after death.					
23A. SIGNATURE <b>Carlos A. Lea Plaza</b> MD DEGREE				23B. DATE SIGNED <b>1/26/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>CARLOS A. LEA PLAZA</b> DEGREE				23D. ADDRESS <b>110 W. 39 ST. BALTIMORE MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/29/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Baltimore, Maryland</b>	

UNION MEMORIAL HOSPITAL

MALE WHITE

DECEASED

MICHAEL PISZECKI

8000 10TH AVE N. PISZECKI, MI

CARDIAC ARREST

COLON SIGMOID CANCER

X

1/25/11

12/25/10

1/25

1/25/11

X

MD

Legal

110 W 34TH ST BALTIMORE MD

CAROL A. LEE PAIN

FUNERAL DIRECTOR: IMPORTANT

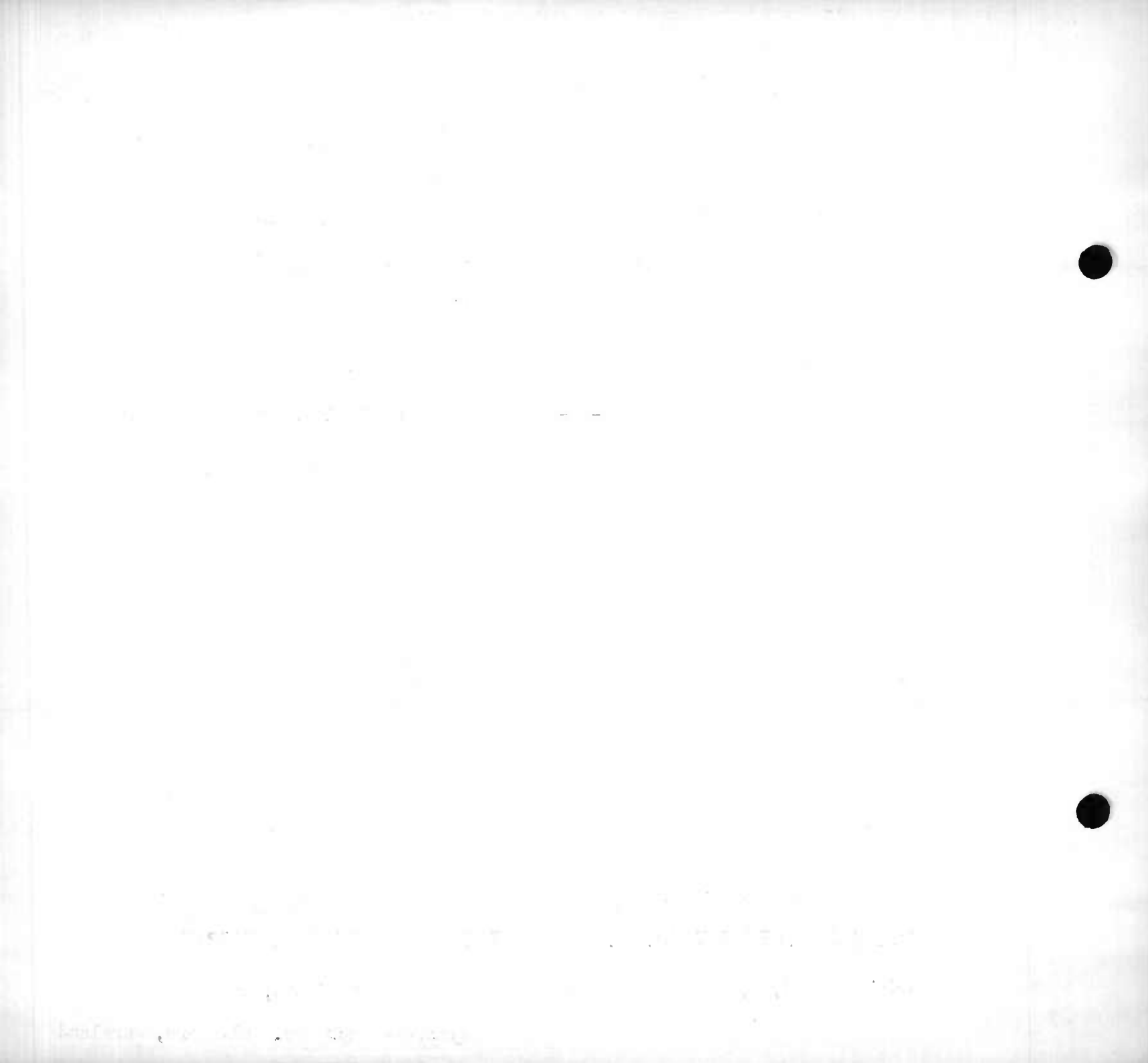
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0966

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 0966

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MARIA FIAMINGO</b>		2. DATE AND HOUR OF DEATH <b>1/25/69 2:30 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>44 Union Memorial Hosp.</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>27-44</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hosp.</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>5916 GLENOAK AVE</b>					
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/30/94</b>	9. AGE (in years last birthday) <b>74</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>ITALY</b>	
13. FATHER'S NAME <b>JOSEPH CASALE</b>			14. MOTHER'S MAIDEN NAME <b>JACKLYN PALMIERI</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-22-5539</b>		17. INFORMANT <b>Mr Enrico Fiamingo 1360 Walker Ave</b>	
18. <b>25-0.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE WITH ACUTE M.I.</b> (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) DIABETES MELLITUS DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) _____</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>1/21/69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>RND 4-3RD DEGREE RU Block</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1/20 1969</b> to <b>1/25 1969</b> that (I) (we) last saw the deceased alive on <b>1/25 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>W. H. Oehlert Jr. MD</b>				23B. DATE SIGNED <b>1/25/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>WILLIAM H. OEHLERT JR. MD.</b>		23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/28/69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>		25B. NAME OF REGISTRAR <b>Wesley G. Galt</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Baltimore, Maryland</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 0967

BIRTH NO.

## 1. NAME OF DECEASED

(Type or Print)

~~EDDIE~~ EATON, Theresa Grace

## 2. DATE OF DEATH

Known ☐

Month

Day

Year

Hour

Estimated ☐

January 23, 1969

4:35 P. M.

## 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

39 PROVIDENT HOSPITAL

## 3. DATE PRONOUNCED DEAD

Month

Day

Year

Hour

January 23, 1969

4:35 P. M.

## 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

27-49

## 6. SEX

Female

## 7. RACE

White

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

## C. CITY OR TOWN

Baltimore

## D. INSIDE CITY LIMITS?

YES ☒NO ☐

## 9. DATE OF BIRTH

March 1, 1914

## 10. AGE (In years last birthday)

54 452

## 11. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

## 11. BIRTHPLACE (State or foreign country)

Maryland

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

Joseph Bunjon

## 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Bindrey

## 14B. KIND OF BUSINESS OR INDUSTRY

Dulany-Vernay Inc

## 15. MOTHER'S MAIDEN NAME

Bontaine LaRosa

## 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

## 17. SOCIAL SECURITY NO.

215-07-663 6

## 18. INFORMANT

Ernest Eaton Sr

## ADDRESS

Same

## 19.

412.4

## CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

## DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

## (A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

## (B)

DUE TO, OR AS A CONSEQUENCE OF:

## (C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

## 20A. DATE OF OPERATION

## 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

## 21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

## 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

## 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

## 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

## 22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

## 22F. HOW DID INJURY OCCUR?

## 23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/24/69

## 24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

## 24B. DATE

1/27/69

## 24C. NAME OF CEMETERY or CREMATORY

Stablersville

## 24D. LOCATION (City, town, or county)

Baltimore County Maryland

## 25A. DATE REC'D BY HEALTH DEPT.

## 25B. NAME OF REGISTRAR

## 25C. FUNERAL DIRECTOR

## ADDRESS

Leonard J Ruck Inc Baltimore, Maryland

EXHIBIT 1, Internal Use

X

March 1971 20 XX

... ..

... ..

... ..

MAILED 100  
APR 1971

*Handwritten signature*

... ..

... ..



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0968

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

69 0968

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Jarvis, Melvin Edwin</b>		2. DATE AND HOUR OF DEATH <b>January 24, 1969</b>   <b>12:30 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		5. CITY OR TOWN <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>23 Veterans Administration Hospital</b> <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>		E. STREET AND NUMBER <b>748 Overbrook Rd.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-25-10</b>	9. AGE (in years last birthday) <b>59</b>	10. If Under 1 Yr. Months   Days   Hours   Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steam Fitter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>William H. Jarvis</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Feldner</b>	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1-13-43 to 10-29-45</b>		17. INFORMANT <b>Records V. A. Hospital</b> ADDRESS <b>3900 Loch Raven Blvd., Baltimore, Md. 21218</b>	
18. <b>571.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.) <b>Shock and Asphyxia</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Massive Hemorrhage in Lungs, ?Actiology</b> DUE TO, OR AS A CONSEQUENCE OF: <b>?Aspiration.</b>			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<b>Liver Cirrhosis, oesophagitis, chronic duod. ulcer</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Yes</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 24, 1969</b> to <b>January 24, 1969</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 24, 1969</b> and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Nagui R. El-Bayadi</b>		23B. DATE SIGNED <b>1-25-69</b>		23C. PHYSICIAN'S NAME (Typo) <b>Nagui R. El-Bayadi, M. D.</b>	
23D. ADDRESS <b>V. A. Hospital, 3900 Loch Raven Blvd. Baltimore, Maryland 21218</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/28/69</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>	
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc, Baltimore, Maryland</b>		25D. ADDRESS	

00. 1. 5. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 83

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

|  |                             |  |   |  |
|--|-----------------------------|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>BERTHA I BAKER</b>   |                             | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> <b>January 23, 1969</b>  |   | Hour<br><b>2:18 P.</b>   |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>33 JOHNS HOPKINS HOSPITAL</b>   |                             | 3. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>January 23, 1969</b>   |   | Hour<br><b>2:18 P.</b>   |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>7-02</b>  |                             |  |   |  |
| 6. SEX<br><b>Female</b>  | 7. RACE<br><b>White</b>     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                       |   | C. CITY OR TOWN<br><b>Baltimore</b>  |
| 9. DATE OF BIRTH<br><b>May 20, 1909</b>  |                             | 10. AGE (In years lost birthday) <b>59</b>   | E. STREET AND NUMBER<br><b>537 N. Lakewood Avenue</b> |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                             | 12. CITIZEN OF<br><b>U.S.A.</b>  | 13. FATHER'S NAME<br><b>Schrivier</b>                 |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                             | 14B. KIND OF BUSINESS OR INDUSTRY  |   | 15. MOTHER'S MAIDEN NAME<br><b>?</b>   |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                             | 17. SOCIAL SECURITY NO.  |   | 18. INFORMANT<br><b>Anna Jones</b> ADDRESS<br><b>2925 Fait Ave</b>             |
| 19. <b>412.4</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |                             | CAUSE OF DEATH<br><b>Arteriosclerotic cardiovascular disease</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____ |   |  |
| 20A. DATE OF OPERATION<br><b>2</b>   |                             | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 21. AUTOPSY? (Yes or No)<br><b>yes</b>   |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                             | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)       |
| 22D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |                             | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 22F. HOW DID INJURY OCCUR?   |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |                             |  |   |  |
| ACTUAL SIGNATURE<br><b>Ronald N. Kornblum, M.D.</b>  |                             | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>               |   | DATE SIGNED<br><b>1/24/69</b>  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 24B. DATE<br><b>1/27/69</b> | 24C. NAME of CEMETERY or CREMATORY<br><b>Baltimore, National</b>   |   | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>    |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 27 1969</b>  |                             | 25B. NAME OF REGISTRAR<br><b>Robert E. Farley</b>  |   | 25C. FUNERAL DIRECTOR ADDRESS<br><b>Leonard J Ruck Inc Baltimore, Maryland</b> |

Receiver

U.S.A.

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Anna Jones 5255 Main Ave

NO

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WATKINS

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |           |   |                  | REG. NO.   |
|--|-----------|---|------------------|--|
| 69 0970  |           |   |                  | 69 0970  |
| BIRTH NO.  |           |   |                  |  |
| 1. NAME OF DECEASED<br>(Type or Print)   |           | 2. DATE AND HOUR OF DEATH   |                  |  |
| WEINBERGER LAURA L   |           | 1/23/69 9 PM M.   |                  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |           | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)   |                  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |           | A. STATE B. COUNTY  |                  |  |
| Union Memorial Hosp  |           | Maryland 27-35  |                  |  |
|  |           | C. CITY OR TOWN   |                  | D. INSIDE CITY LIMITS?   |
|  |           | Baltimore   |                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |
|  |           | E. STREET AND NUMBER  |                  |  |
|  |           | 7618 Daniels Ave  |                  |  |
| 5. SEX   | 6. RACE   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday)  |
| F  | W         |   | 3/6/88           | 81   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |           | 10B. KIND OF BUSINESS OR INDUSTRY   |                  | 11. BIRTHPLACE (State or foreign country)                                |
| Housewife  |           |   |                  | MD.  |
| 13. FATHER'S NAME  |           | 14. MOTHER'S MAIDEN NAME  |                  |  |
| Singleton T Bryden   |           | Mary Crouch   |                  |  |
| 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) (If yes, give war or dates of service)  |           | 16. SOCIAL SECURITY NO.   |                  | 17. INFORMANT ADDRESS  |
| No   |           | 220-12-6719 A   |                  | JOHN T. WEINBERGER   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH   |           | CAUSE OF DEATH  |                  |  |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)   |           | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:   |                  |  |
| ANTECEDENT CAUSES  |           | INTRACEREBRAL HEMORRHAGE  |                  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |           | (B) HASCVD  |                  |  |
|  |           | (C)   |                  |  |
| II   |           |   |                  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |           |   |                  |  |
| 19A. DATE OF OPERATION   |           | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                  | 20A. AUTOPSY? (Yes or No)  |
|  |           |   |                  | NO   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |           | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|  |           |   |                  |  |
| 21D. TIME OF INJURY (APPROX.)  |           | 21E. INJURY OCCURRED  |                  | 21F. HOW DID INJURY OCCUR?   |
| (Month) (Day) (Year) (Hour)  |           | While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 1/22/69 19 to 1/23 19 69, that (I) (we) last saw the deceased alive on 1/23 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |           |   |                  |  |
| 23A. SIGNATURE   |           |   |                  | 23B. DATE SIGNED   |
| Charles S. Brown MD  |           |   |                  | 1/23/69  |
| 23C. PHYSICIAN'S NAME (Type)   |           |   |                  | 23D. ADDRESS   |
| CHARLES S. BROWN MD.   |           |   |                  | THE UNION MEMORIAL HOSPITAL  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY  |                  | 24D. LOCATION (City, town, or county) (State)                            |
| Burial   | 1/27/69   | Moreland Memorial Park  |                  | Baltimore, Maryland  |
| 25A. DATE REC'D BY HEALTH DEPT.  |           | 25B. NAME OF REGISTRAR  |                  | 25C. FUNERAL DIRECTOR ADDRESS  |
| JAN 27 1969  |           | Robert E. Stashy, MD  |                  | Leonard J Ruck Inc. Baltimore, Maryland                                  |

100-11-11-11

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0971

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 69 0971

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| BIRTH NO.   |  | 1. NAME OF DECEASED<br>(Type or Print) <b>HENRY<sup>B</sup> PETERSAM</b>                               |  | 2. DATE AND HOUR OF DEATH<br><b>1/26/69 9.00 A M.</b>  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  |  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>             |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>CHURCH HOME &amp; HOSP.</b>  |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>BALTO-31</b>                |  | C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                              |  |
| 5. SEX <b>MALE</b>  |  | 6. RACE <b>W</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED</b>   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Western Electric Co</b>  |  | 9. AGE (In years last birthday) <b>67</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | E. STREET AND NUMBER<br><b>Box 217 Rt. 14 Gun Powder Rd 21220</b>  |  |
| 13. FATHER'S NAME<br><b>JOHN PETERGAM</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>MINNIE XXXXXXX Nuth</b>   |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No unknown</b>                            |  |
| 16. SOCIAL SECURITY NO.<br><b>216-01-9273</b>   |  | 17. INFORMANT<br><b>Mrs Frances B Petersam</b>   |  | ADDRESS<br><b>4613 Schley Ave</b>  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Acute Cardiac infarction</b>   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b>  |  |  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>Acute Renal Insufficiency</b>                |  | <b>1 day</b>   |  |
|   |  | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>Arteriosclerotic Heart disease</b>                           |  | <b>Few years</b>   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |  |  |  |  |
| 19A. DATE OF OPERATION<br><b>1/21/69</b>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>G.I. BLEEDING</b>                               |  | 20A. AUTOPSY? (Yes or No) <b>NO.</b>   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>1/20/1969</b> to <b>1/26/1969</b> , that (I) (we) last saw the deceased alive on <b>1/26/1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |  |  |
| 23A. SIGNATURE<br><b>Krishna Reddy</b>  |  | 23B. DATE SIGNED<br><b>1/26/69</b>   |  | 23C. PHYSICIAN'S NAME (Type)<br><b>KRISHNA REDDY</b>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>1/30/69</b>  |  | 24C. NAME of CEMETERY or CREMATORY<br><b>Gardens Of Faith</b>  |  |
| 24D. LOCATION<br><b>Baltimore, Maryland</b>   |  | 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 27 1969</b>  |  | 25B. NAME OF REGISTRAR<br><b>John E. Johnson</b>   |  |
| 25C. FUNERAL DIRECTOR<br><b>Leonard J. Ruck Inc.</b>  |  | 25D. ADDRESS<br><b>Baltimore, Maryland</b>   |  |  |  |

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 0972

BIRTH NO.

|   |  |   |  |
|---|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>ALPHONSO A. HUGHES</b>   |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> 1 25 69 7:30 a M.   |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>44 Union Memorial Hospital</b>   |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>January 25, 1969 7:30 a M.</b>   |  |
| 6. SEX<br><b>Male</b>   |  | 7. RACE<br><b>White</b>   |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>12-12</b>   |  |
| 9. DATE OF BIRTH<br><b>June 21, 1906</b>  |  | 10. AGE (In years last birthday)<br><b>62</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Scotland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Eng. Eng.</b>   |  | 14B. KIND OF BUSINESS OR INDUSTRY<br><b>Martin Co</b>   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  | 17. SOCIAL SECURITY NO.<br><b>217-03-9901</b>   |  |
| 18. INFORMANT<br><b>Mrs Ellen Lang</b>  |  | ADDRESS<br><b>2909 Markley Ave</b>  |  |
| 19. CAUSE OF DEATH<br><b>E887 X</b>   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  |  | (A) IMMEDIATE CAUSE<br><b>Pneumonia complicating fractured hip</b><br>DUE TO, OR AS A CONSEQUENCE OF:   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |  | (B) DUE TO, OR AS A CONSEQUENCE OF:   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |  | (C) DUE TO, OR AS A CONSEQUENCE OF:   |  |
| 20A. DATE OF OPERATION  |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.   |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Street</b>   |  |
| 22D. TIME OF INJURY (APPROX.)<br>1 14 69 1:30 p   |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br><b>South Greemont, 3300 block</b>   |  | 22F. HOW DID INJURY OCCUR?<br><b>Fell on sidewalk</b>   |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |
| ACTUAL SIGNATURE<br><b>Edward F. Wilson</b><br>EXAMINER'S NAME (Type)<br><b>Edward F. Wilson, M.D.</b>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED<br><b>1/26/69</b> |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>1/29/69</b>   |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Moreland Memorial Park</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 27 1969</b>   |  | 25B. NAME OF REGISTRAR<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>  |  |
| 25C. FUNERAL DIRECTOR<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>   |  | ADDRESS   |  |

1977

7: 02  
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James H. Jones  
The Church of Jesus Christ of Latter-day Saints  
Salt Lake City, Utah 84143

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT

## 69 0973 CERTIFICATE OF DEATH

REG. NO. 69 0973

|  |                  |   |  |  |  |  |  |   |  |  |  |  |  |   |  |   |  |  |  |  |  |  |  |   |  |  |  |                            |  |   |  |  |  |  |  |   |  |  |  |                                 |  |   |  |  |  |              |  |  |  |                          |  |  |  |   |  |                               |  |  |  |  |  |  |  |   |  |
|--|------------------|---|--|--|--|--|--|---|--|--|--|--|--|---|--|---|--|--|--|--|--|--|--|---|--|--|--|----------------------------|--|---|--|--|--|--|--|---|--|--|--|---------------------------------|--|---|--|--|--|--------------|--|--|--|--------------------------|--|--|--|---|--|-------------------------------|--|--|--|--|--|--|--|---|--|
| BIRTH NO.  |                  | 1. NAME OF DECEASED<br>(Type or Print) <b>Helen Virginia Bowden</b>   |  | 2. DATE AND HOUR OF DEATH<br><b>1/24/69 12-50A M.</b>                    |  |  |  |   |  |  |  |  |  |   |  |   |  |  |  |  |  |  |  |   |  |  |  |                            |  |   |  |  |  |  |  |   |  |  |  |                                 |  |   |  |  |  |              |  |  |  |                          |  |  |  |   |  |                               |  |  |  |  |  |  |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> |  |  |  |  |   |  |  |  |  |  |   |  |   |  |  |  |  |  |  |  |   |  |  |  |                            |  |   |  |  |  |  |  |   |  |  |  |                                 |  |   |  |  |  |              |  |  |  |                          |  |  |  |   |  |                               |  |  |  |  |  |  |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>48 Maryland General Hosp</b>  |                  |   | C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                             |  |  |  |  |   |  |  |  |  |  |   |  |   |  |  |  |  |  |  |  |   |  |  |  |                            |  |   |  |  |  |  |  |   |  |  |  |                                 |  |   |  |  |  |              |  |  |  |                          |  |  |  |   |  |                               |  |  |  |  |  |  |  |   |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |                  |   | E. STREET AND NUMBER <b>6001 Starlight Rd</b>  |  |  |  |  |   |  |  |  |  |  |   |  |   |  |  |  |  |  |  |  |   |  |  |  |                            |  |   |  |  |  |  |  |   |  |  |  |                                 |  |   |  |  |  |              |  |  |  |                          |  |  |  |   |  |                               |  |  |  |  |  |  |  |   |  |
| 5. SEX <b>F</b>  | 6. RACE <b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10/15/09</b>  | 9. AGE (In years last birthday) <b>59</b>                                | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |  |  |   |  |  |  |  |  |   |  |   |  |  |  |  |  |  |  |   |  |  |  |                            |  |   |  |  |  |  |  |   |  |  |  |                                 |  |   |  |  |  |              |  |  |  |                          |  |  |  |   |  |                               |  |  |  |  |  |  |  |   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>   |                  | 10B. KIND OF BUSINESS OR INDUSTRY <b>General Electric</b>   |  | 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>                |  |  |  |   |  |  |  |  |  |   |  |   |  |  |  |  |  |  |  |   |  |  |  |                            |  |   |  |  |  |  |  |   |  |  |  |                                 |  |   |  |  |  |              |  |  |  |                          |  |  |  |   |  |                               |  |  |  |  |  |  |  |   |  |
| 13. FATHER'S NAME <b>Memell J. Smith</b>   |                  | 14. MOTHER'S M maiden NAME <b>Nancy Elizabeth Bebee</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                               |  |  |  |   |  |  |  |  |  |   |  |   |  |  |  |  |  |  |  |   |  |  |  |                            |  |   |  |  |  |  |  |   |  |  |  |                                 |  |   |  |  |  |              |  |  |  |                          |  |  |  |   |  |                               |  |  |  |  |  |  |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>   |                  | 16. SOCIAL SECURITY NO. <b>224-14-8840</b>  |  | 17. INFORMANT <b>Wm. L. Bowden</b> ADDRESS <b>same</b>                   |  |  |  |   |  |  |  |  |  |   |  |   |  |  |  |  |  |  |  |   |  |  |  |                            |  |   |  |  |  |  |  |   |  |  |  |                                 |  |   |  |  |  |              |  |  |  |                          |  |  |  |   |  |                               |  |  |  |  |  |  |  |   |  |
| <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br/>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br/><b>162-1 I</b></td> <td colspan="2">CAUSE OF DEATH<br/>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>BRAIN Tumor Metastasis</b></td> <td colspan="2">APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</td> </tr> <tr> <td colspan="2">ANTECEDENT CAUSES<br/>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</td> <td colspan="2">(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Bronchopneumonia</b></td> <td colspan="2"></td> </tr> <tr> <td colspan="2"></td> <td colspan="2">(C) <b>Ca. of Lung</b></td> <td colspan="2"></td> </tr> </table>   |                  |   |  |  |  | 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>162-1 I</b> |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>BRAIN Tumor Metastasis</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  | ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  | (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Bronchopneumonia</b> |  |   |  |  |  | (C) <b>Ca. of Lung</b>   |  |  |  |   |  |  |  |                            |  |   |  |  |  |  |  |   |  |  |  |                                 |  |   |  |  |  |              |  |  |  |                          |  |  |  |   |  |                               |  |  |  |  |  |  |  |   |  |
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| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                  | (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Bronchopneumonia</b>   |  |  |  |  |  |   |  |  |  |  |  |   |  |   |  |  |  |  |  |  |  |   |  |  |  |                            |  |   |  |  |  |  |  |   |  |  |  |                                 |  |   |  |  |  |              |  |  |  |                          |  |  |  |   |  |                               |  |  |  |  |  |  |  |   |  |
|  |                  | (C) <b>Ca. of Lung</b>  |  |  |  |  |  |   |  |  |  |  |  |   |  |   |  |  |  |  |  |  |  |   |  |  |  |                            |  |   |  |  |  |  |  |   |  |  |  |                                 |  |   |  |  |  |              |  |  |  |                          |  |  |  |   |  |                               |  |  |  |  |  |  |  |   |  |
| <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="6">II<br/>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</td> </tr> <tr> <td colspan="2">19A. DATE OF OPERATION</td> <td colspan="2">19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</td> <td colspan="2">20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/></td> </tr> <tr> <td colspan="2">21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></td> <td colspan="2">21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</td> <td colspan="2">21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</td> </tr> <tr> <td colspan="2">21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</td> <td colspan="2">21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></td> <td colspan="2">21F. HOW DID INJURY OCCUR?</td> </tr> <tr> <td colspan="6">22. I certify that (I) (this hospital) attended the deceased from <b>12/12</b> 19 <b>68</b> to <b>1/24</b> 19 <b>69</b>, that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</td> </tr> <tr> <td colspan="4">23A. SIGNATURE <b>Miguel A. Myia</b> OEGREE</td> <td colspan="2">23B. DATE SIGNED <b>1/24/69</b></td> </tr> <tr> <td colspan="4">23C. PHYSICIAN'S NAME (Type) <b>Miguel A. Myia</b> DEGREE</td> <td colspan="2">23D. ADDRESS</td> </tr> <tr> <td colspan="2">24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b></td> <td colspan="2">24B. DATE <b>1/27/69</b></td> <td colspan="2">24C. NAME OF CEMETERY or CREMATORY <b>Parsons Cem.</b></td> </tr> <tr> <td colspan="2">24D. LOCATION (City, town, or county) <b>Salisbury, Md.</b></td> <td colspan="4">24E. STATE (State) <b>Md.</b></td> </tr> <tr> <td colspan="2">25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b></td> <td colspan="2">25B. NAME OF REGISTRAR <b>Leonard J. Ruck Inc.</b></td> <td colspan="2">25C. FUNERAL DIRECTOR ADDRESS <b>Balto. Md.</b></td> </tr> </table> |                  |   |  |  |  | II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |  |   |  |  |  | 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED            |  | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> |  | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR? |  | 22. I certify that (I) (this hospital) attended the deceased from <b>12/12</b> 19 <b>68</b> to <b>1/24</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |  |  | 23A. SIGNATURE <b>Miguel A. Myia</b> OEGREE |  |  |  | 23B. DATE SIGNED <b>1/24/69</b> |  | 23C. PHYSICIAN'S NAME (Type) <b>Miguel A. Myia</b> DEGREE |  |  |  | 23D. ADDRESS |  | 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b> |  | 24B. DATE <b>1/27/69</b> |  | 24C. NAME OF CEMETERY or CREMATORY <b>Parsons Cem.</b> |  | 24D. LOCATION (City, town, or county) <b>Salisbury, Md.</b> |  | 24E. STATE (State) <b>Md.</b> |  |  |  | 25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b> |  | 25B. NAME OF REGISTRAR <b>Leonard J. Ruck Inc.</b> |  | 25C. FUNERAL DIRECTOR ADDRESS <b>Balto. Md.</b> |  |
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| 19A. DATE OF OPERATION   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>            |  |  |  |   |  |  |  |  |  |   |  |   |  |  |  |  |  |  |  |   |  |  |  |                            |  |   |  |  |  |  |  |   |  |  |  |                                 |  |   |  |  |  |              |  |  |  |                          |  |  |  |   |  |                               |  |  |  |  |  |  |  |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |  |  |   |  |  |  |  |  |   |  |   |  |  |  |  |  |  |  |   |  |  |  |                            |  |   |  |  |  |  |  |   |  |  |  |                                 |  |   |  |  |  |              |  |  |  |                          |  |  |  |   |  |                               |  |  |  |  |  |  |  |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?   |  |  |  |   |  |  |  |  |  |   |  |   |  |  |  |  |  |  |  |   |  |  |  |                            |  |   |  |  |  |  |  |   |  |  |  |                                 |  |   |  |  |  |              |  |  |  |                          |  |  |  |   |  |                               |  |  |  |  |  |  |  |   |  |
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| 23A. SIGNATURE <b>Miguel A. Myia</b> OEGREE  |                  |   |  | 23B. DATE SIGNED <b>1/24/69</b>  |  |  |  |   |  |  |  |  |  |   |  |   |  |  |  |  |  |  |  |   |  |  |  |                            |  |   |  |  |  |  |  |   |  |  |  |                                 |  |   |  |  |  |              |  |  |  |                          |  |  |  |   |  |                               |  |  |  |  |  |  |  |   |  |
| 23C. PHYSICIAN'S NAME (Type) <b>Miguel A. Myia</b> DEGREE  |                  |   |  | 23D. ADDRESS   |  |  |  |   |  |  |  |  |  |   |  |   |  |  |  |  |  |  |  |   |  |  |  |                            |  |   |  |  |  |  |  |   |  |  |  |                                 |  |   |  |  |  |              |  |  |  |                          |  |  |  |   |  |                               |  |  |  |  |  |  |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>   |                  | 24B. DATE <b>1/27/69</b>  |  | 24C. NAME OF CEMETERY or CREMATORY <b>Parsons Cem.</b>                   |  |  |  |   |  |  |  |  |  |   |  |   |  |  |  |  |  |  |  |   |  |  |  |                            |  |   |  |  |  |  |  |   |  |  |  |                                 |  |   |  |  |  |              |  |  |  |                          |  |  |  |   |  |                               |  |  |  |  |  |  |  |   |  |
| 24D. LOCATION (City, town, or county) <b>Salisbury, Md.</b>  |                  | 24E. STATE (State) <b>Md.</b>   |  |  |  |  |  |   |  |  |  |  |  |   |  |   |  |  |  |  |  |  |  |   |  |  |  |                            |  |   |  |  |  |  |  |   |  |  |  |                                 |  |   |  |  |  |              |  |  |  |                          |  |  |  |   |  |                               |  |  |  |  |  |  |  |   |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1969</b>   |                  | 25B. NAME OF REGISTRAR <b>Leonard J. Ruck Inc.</b>  |  | 25C. FUNERAL DIRECTOR ADDRESS <b>Balto. Md.</b>                          |  |  |  |   |  |  |  |  |  |   |  |   |  |  |  |  |  |  |  |   |  |  |  |                            |  |   |  |  |  |  |  |   |  |  |  |                                 |  |   |  |  |  |              |  |  |  |                          |  |  |  |   |  |                               |  |  |  |  |  |  |  |   |  |

CHICAGO, ILL.

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R-362

69 0974 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 0974

REG. NO.

BIRTH NO.

|  |  |   |  |
|--|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Wilhelmina</b><br><b>LENA W. RITTERSHOFER</b>  |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> 1 25 69 3:55 a.m. |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Union Memorial Hospital D.O.A.</b>   |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>January 25, 1969 3:55 a.m.</b>   |  |
| 6. SEX <b>Female</b>   |  | 7. RACE <b>White</b>  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | C. CITY OR TOWN <b>Balto.</b>   |  |
| 9. DATE OF BIRTH<br><b>Jan. 10, 1906</b>   |  | 10. AGE (In years last birthday) <b>63</b><br>If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.                                      |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 14B. KIND OF BUSINESS OR INDUSTRY   |  |
| 15. MOTHER'S MAIDEN NAME<br><b>Anna Black</b>  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                   |  |
| 17. SOCIAL SECURITY NO.<br><b>216-01-4425</b>  |  | 18. INFORMANT<br><b>Edward J Rittershofer 9 Staley Ct.</b>  |  |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerotic cardiovascular disease</b>   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |  | (B) DUE TO, OR AS A CONSEQUENCE OF:   |  |
| 20A. DATE OF OPERATION   |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 21. AUTOPSY? (Yes or No)<br><b>No</b>  |  |   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?   |  |   |  |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                 |  |
| 22F. HOW DID INJURY OCCUR?   |  |   |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Edward F. Wilson, M.D.</b> M.D.<br>EXAMINER'S NAME (Type)<br>DATE SIGNED <b>1/25/69</b> |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>1/27/69</b>   |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Parkwood</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 27 1969</b>  |  | 25B. NAME OF REGISTRAR<br><b>Leonard J Ruck Inc.</b>  |  |
| 25C. FUNERAL DIRECTOR ADDRESS<br><b>Baltimore, Maryland</b>  |  |   |  |

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69 0975 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 0975

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

RAYMOND LONG

2. DATE OF DEATH Known ☒ Estimated ☐ Month Day Year Hour  
1 24 69 10:00 pm.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

37 Mercy Hospital

3. DATE PRONOUNCED DEAD Month Day Year Hour  
January 24, 1969 10:00pm.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

6. SEX

Male

7. RACE

Colored

8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

9. DATE OF BIRTH

2/22/41

10. AGE (In years lost birthday) 27

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

711 E. Preston St.

10-01

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Raymond Long Sr.

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Unknown

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Isabelle Wesley 1521 N. Caroline St

19. CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Gunshot wound of the chest  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Street

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

600 blk. E. Biddle St.

10-04

22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

1 24 69 9:45p m.

22E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject shot

23. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE

Edward F. Wilson

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Edward F. Wilson, M.D.

1/25/69

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1/30/69

24C. NAME OF CEMETERY OR CREMATORY

Mt Auburn Cemetery

24D. LOCATION (City, town, or county) (State)

Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 27 1969

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

Wm C March

ADDRESS

928 E North Ave.

NO 1002

NO 1002

1002

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WALTER

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0976

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

69 0976

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| BIRTH NO.  |  | 1. NAME OF DECEASED<br>(Type or Print) <b>MORRISON, DORIS F.</b>                                       |  | 2. DATE AND HOUR OF DEATH<br><b>1/23/69 7:30 A.M.</b>  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>             |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>33 The Johns Hopkins Hospital</b>   |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                   |  | C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 5. SEX <b>Female</b>   |  | 6. RACE <b>N</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Packer</b>   |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 8. DATE OF BIRTH <b>2/22/23</b> 9. AGE (In years last birthday) <b>45</b>  |  |
| 13. FATHER'S NAME<br><b>Edward Eldridge</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Deshields</b>  |  | 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO.  |  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 17. INFORMANT<br><b>Robert L. Morrison</b>   |  | ADDRESS<br><b>1915 E. North Ave</b>  |  |  |  |
| 18. <b>403X1</b> CAUSE OF DEATH  |  |  |  |  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>renal failure - anoxemia and cardiac failure</b>  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Rob. Past yr.</b>   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>long standing hypertension</b>  |  |  |  | (B) <b>&gt; 10 yrs.</b>  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |  |  |  |  |  |
| 19A. DATE OF OPERATION <b>2/1</b>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No) <b>Yes</b>   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (1) (this hospital) attended the deceased from <b>1/18 1969</b> to <b>1/23 1969</b> and that (2) (we) last saw the deceased alive on <b>1/23 1969</b> and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. |  |  |  |  |  |
| 23A. SIGNATURE<br><b>Edward D. Frank Jr. M.D.</b>  |  |  |  | 23B. DATE SIGNED<br><b>1/23/69</b>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Edward D. Frank Jr. M.D.</b>  |  | 23D. ADDRESS<br><b>1519 E. Monument St. Baltimore Md.</b>  |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>1/28/69</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Balto National Cemetery</b>   |  |
| 24D. LOCATION<br><b>Balto., Md.</b>  |  | 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 27 1969</b>  |  |  |  |
| 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor</b>  |  | 25C. FUNERAL DIRECTOR<br><b>Wm Co March</b>  |  |  |  |
| ADDRESS<br><b>928 E. North Ave.</b>  |  |  |  |  |  |

*[Handwritten notes:]*

10/10/19  
Cerebral cortex - cytoplasm and nucleus  
Cerebellum - cytoplasm and nucleus

6. m. f. 1000. 1000. 1000.  
 6. m. f. 1000. 1000. 1000.

1219 E. Main Street  
1/31/98

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
69 0977 CERTIFICATE OF DEATH

REG. NO.

69 0977

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

George Vathis

2. DATE AND HOUR OF DEATH

01-26-69, 3:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

Baltimore

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐

NO ☐

E. STREET AND NUMBER

6028 Broadway

5. SEX

Male

6. RACE

White

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

4-21-08

9. AGE (In years last birthday)

60

10. Under 1 Yr.

Months: Days: Hours: Min.

11. Under 24 Hrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

UNKNOWN

11. BIRTHPLACE (State or foreign country)

FERNWOOD - DEL. COUNTY, PA.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Stelios Vathis

14. MOTHER'S MAIDEN NAME

Angeliki Sarinopoulos

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

190-24-3221

17. INFORMANT

Brain Funeral Home -

ADDRESS

Upper Darby, PA.

18.

1621 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Bowel perforation

hours

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Metastatic bronchogenic ca

18 mos

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

2 None

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

—

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

No

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)

☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (the hospital) attended the deceased from

that (I) (we) lost saw the deceased alive on

1-26 19 69 to

1-26 19 69

and that (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Ronald G Michels MD

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1-26-69

23C. PHYSICIAN'S NAME (Type)

Ronald G Michels MD

23D. ADDRESS

Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

2-1-69

24C. NAME OF CEMETERY OR CREMATORY

Fernwood Cemetery

24D. LOCATION (City, town, or county)

Delaware County, Penna.

25A. DATE REC'D BY HEALTH DEPT.

JAN 28 1969

25B. NAME OF REGISTRAR

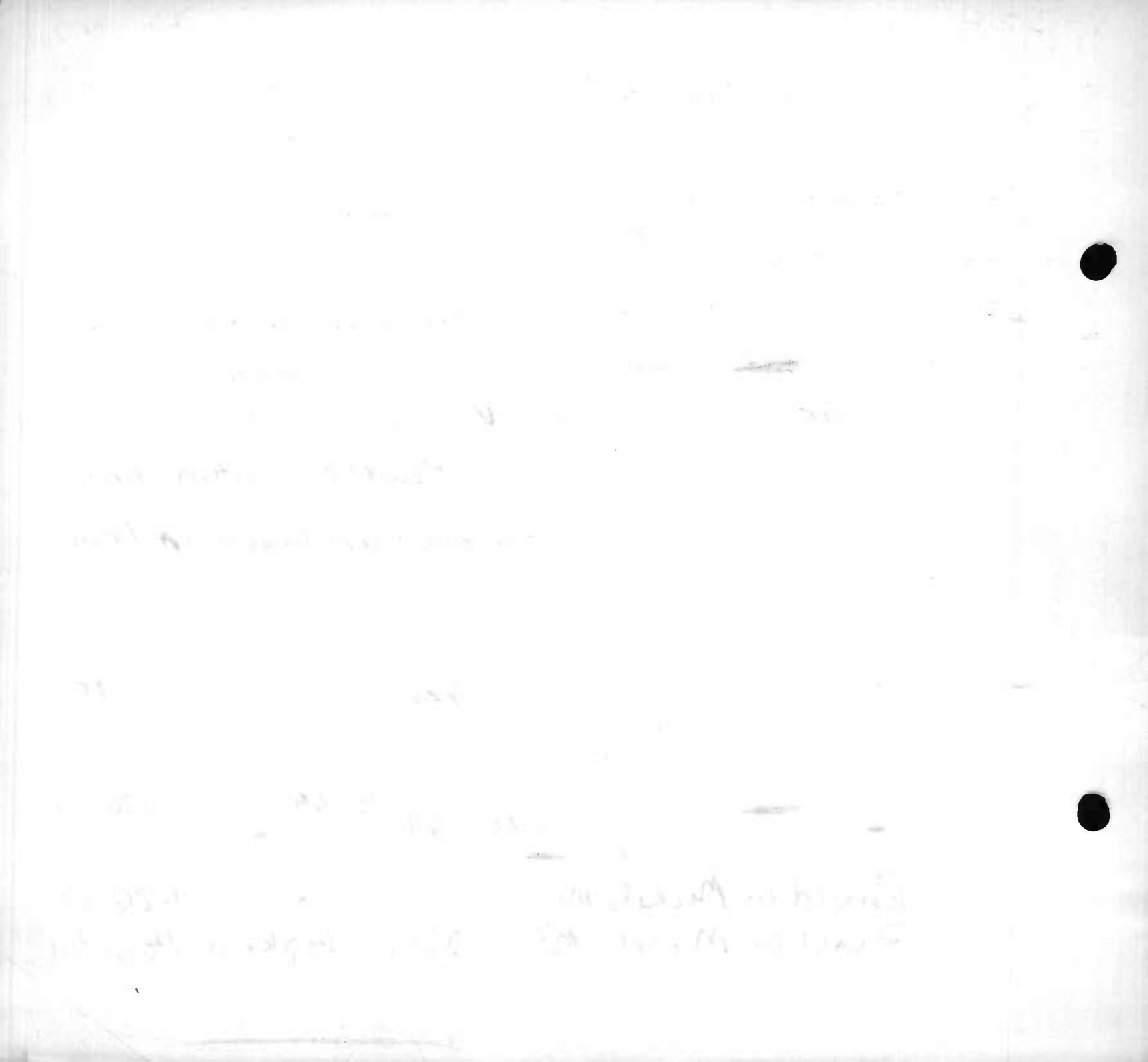
R. A. E. [Signature]

25C. FUNERAL DIRECTOR

[Signature]

ADDRESS

Balto, Md.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 69 0978 CERTIFICATE OF DEATH

REG. NO. **69 0978**

|   |                         |   |                                     |   |   |
|---|-------------------------|---|-------------------------------------|---|---|
| BIRTH NO.   |                         | 1. NAME OF DECEASED<br>(Type or Print) <b>Flemming, Carrie</b>  |                                     | 2. DATE AND HOUR OF DEATH<br><b>1-24-69 1:30 a.</b> M.  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                         | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>14-03</b>   |                                     | C. CITY OR TOWN <b>Baltimore</b>  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>39 Provident Hospital</b><br><b>1514 Division Street</b><br><b>Baltimore, Maryland</b>   |                         | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                     | E. STREET AND NUMBER<br><b>2125 McCulloh Street</b>   |   |
| 5. SEX<br><b>Female</b>   | 6. RACE<br><b>Negro</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>12-26-02</b> | 9. AGE (In years last birthday) <b>66</b>   | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                         | 10B. KIND OF BUSINESS OR INDUSTRY   |                                     | 11. BIRTHPLACE (State or foreign country)<br><b>Georgia</b>   |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |                         | 13. FATHER'S NAME   |                                     | 14. MOTHER'S MAIDEN NAME  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>   |                         | 16. SOCIAL SECURITY NO.<br><b>?</b>   |                                     | 17. INFORMANT<br><b>Mr. Otis Flemming (Husband)</b> ADDRESS <b>Same</b>                                   |   |
| 18. <b>I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Epidermoid Ca</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Senility</b> |                         | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>Epidermoid Ca</b>   |                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |
| (B) DUE TO, OR AS A CONSEQUENCE OF:   |                         | (C) DUE TO, OR AS A CONSEQUENCE OF:   |                                     |   |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                         |   |                                     |   |   |
| 19A. DATE OF OPERATION  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                     | 20A. AUTOPSY? (Yes or No) <b>no</b>   |   |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                         | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |   |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                         | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |                                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   |
| 21F. HOW DID INJURY OCCUR?  |                         | 22. I certify that (I) (this hospital) attended the deceased from <b>1-11-69</b> to <b>19</b> that (I) (we) last saw the deceased alive on <b>19</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                                     |   |   |
| 23A. SIGNATURE<br><b>AHSAN. S. KHAN</b>   |                         | 23B. DATE SIGNED<br><b>1-25-69</b>  |                                     | 23C. PHYSICIAN'S NAME (Type)<br><b>AHSAN. S. KHAN</b>   |   |
| 23D. ADDRESS<br><b>Provident Hospital</b><br><b>1514 Division Street - Baltimore, Maryland</b>  |                         | 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                     | 24B. DATE<br><b>1-29-69</b>   |   |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Arbutus Mem. Pk.</b>   |                         | 24D. LOCATION (City, town, or county) (State)<br><b>Arbutus Maryland</b>  |                                     | 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 28 1969</b>   |   |
| 25B. NAME OF REGISTRAR<br><b>DELSON F. F.</b>   |                         | 25C. FUNERAL DIRECTOR<br><b>V.R. Bailey</b>   |                                     | ADDRESS<br><b>1348 Calhoun Street</b>   |   |

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 69 0979 CERTIFICATE OF DEATH

REG. NO. 68-3676  
69 0979

|  |                        |   |  |  |   |
|--|------------------------|---|--|--|---|
| BIRTH NO.  |                        | 1. NAME OF DECEASED<br>(Type or Print) <u>Daniel Hawkins</u>  |  | 2. DATE AND HOUR OF DEATH<br><u>1-25-69</u> <u>7:30 P.M.</u>   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                        |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>Maryland</u> B. COUNTY <u>17-03</u> |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>46</u><br><u>Lutheran Hospital of Maryland</u>  |                        | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |  | C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>              |   |
| S. SEX<br><u>male</u>  | 6. RACE<br><u>Male</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>1-15-90</u>   | 9. AGE (In years lost birthday) <u>79</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired</u>  |                        | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Longshoreman</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>   |   |
| 13. FATHER'S NAME<br><u>ROBERT HAWKINS</u>   |                        |   |  | 14. MOTHER'S MAIDEN NAME<br><u>HANNAH</u>  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>NO</u>  |                        | 16. SOCIAL SECURITY NO.<br><u>216-12-5704</u>   |  | 17. INFORMANT<br><u>Wife (Jannie)</u>  |   |
| 18. CAUSE OF DEATH<br>Ib. <u>492X I</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><u>peptic ulcer disease inactive 6 M.S.</u> |                        |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 Month</u><br><u>"</u><br><u>"</u>   |   |
| 19A. DATE OF OPERATION<br><u>0</u>   |                        | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><u>no</u>   |   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)  |                        | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |   |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |                        | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <u>1-2-27</u> 19 <u>68</u> to <u>1-25</u> 19 <u>69</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>1-25</u> 19 <u>69</u> and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <u>We</u> ) ( <u>did</u> ) ( <u>did not</u> ) view the body after death.  |                        |   |  |  |   |
| 23A. SIGNATURE<br><u>[Signature]</u>   |                        |   |  | 23B. DATE SIGNED<br><u>1-25-69</u>   |   |
| 23C. PHYSICIAN'S NAME (Type)<br><u>Louis Davy M.D.</u>   |                        | 23D. ADDRESS<br><u>Lutheran Hospital of Maryland</u>  |  |  |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |                        | 24B. DATE<br><u>1-29-69</u>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><u>ARBUTUS MEN. PK.</u>  |   |
| 24D. LOCATION<br><u>ARBUTUS, Md.</u>   |                        | 24E. LOCATION (City, town, or county) (State)   |  |  |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>JAN 28 1969</u>  |                        | 25B. NAME OF REGISTRAR<br><u>[Signature]</u>  |  | 25C. FUNERAL DIRECTOR<br><u>W.R. BAILEY</u>  |   |
| 25D. ADDRESS<br><u>1348 CALHOUN ST.</u>  |                        |   |  |  |   |

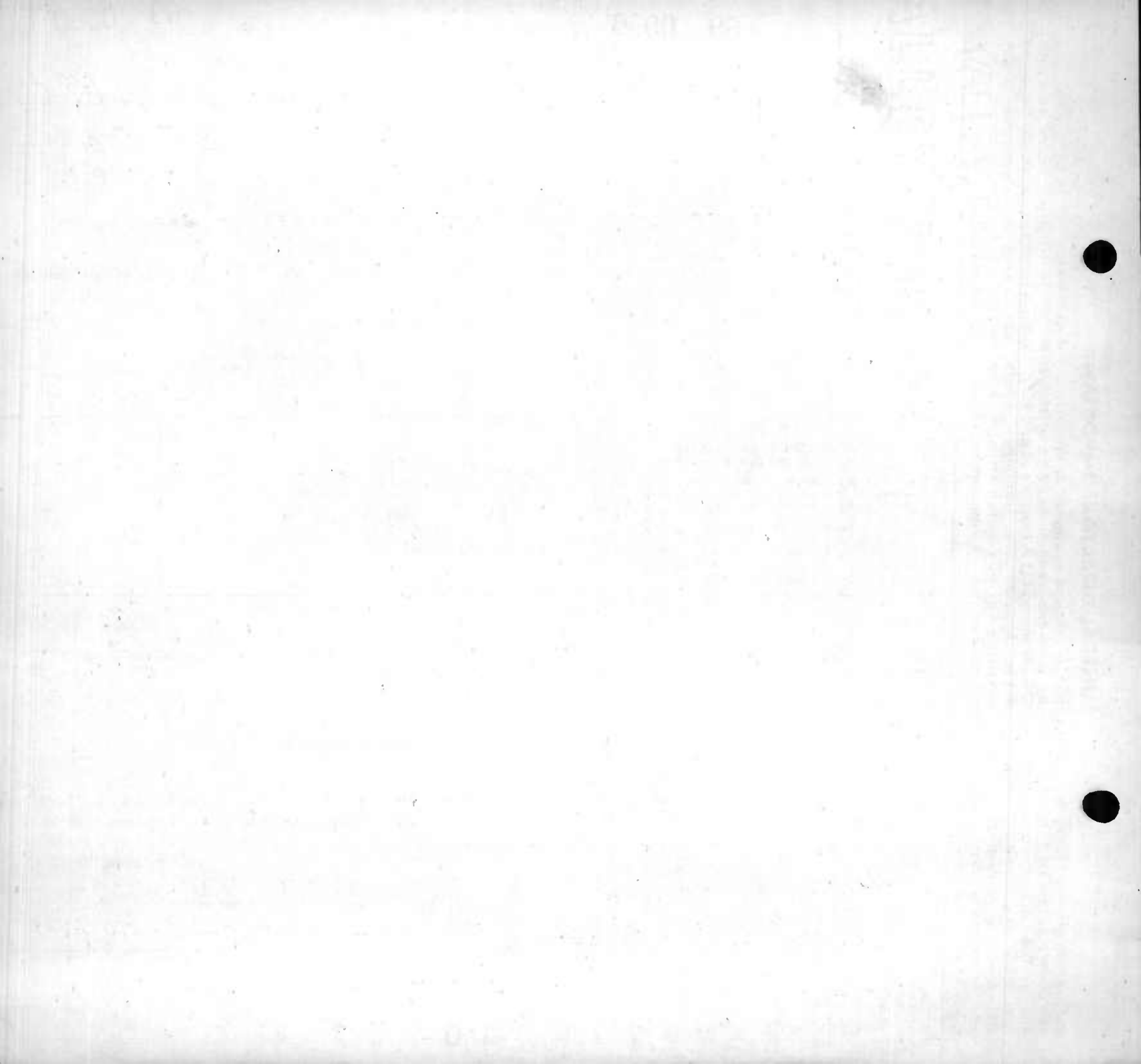




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |         |  |   | 69 0980   |   | REG. NO. 69 0980   |  |
|---|---------|--|---|---|---|--|--|
| BIRTH NO.   |         |  |   | 1. NAME OF DECEASED<br>(Type or Print)  |   | 2. DATE AND HOUR OF DEATH  |  |
|   |         |  |   | CHANELIA ELIZABETH LEWIS  |   | 1-25-69 600 A.M.   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |         |  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |   |  |  |
|   |         |  |   | A. STATE B. COUNTY  |   |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |         |  |   | C. CITY OR TOWN   |   | D. INSIDE CITY LIMITS?   |  |
| MONTEBELLO STATE HOSPITAL   |         |  |   | BALTO.  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| BALTO. 21218  |         |  |   | E. STREET AND NUMBER  |   |  |  |
|   |         |  |   | 2619 GARRETT AVE  |   |  |  |
| 5. SEX  | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>    | 8. DATE OF BIRTH                                    | 9. AGE (In years last birthday)   | If Under 1 Yr. Months: Days:              | If Under 24 Hrs. Hours: Min.   |  |
| FEMALE  | COLORED | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                       | 4-11-17   | 51  |   |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |         |  | 10B. KIND OF BUSINESS OR INDUSTRY                   |   | 11. BIRTHPLACE (State or foreign country) |  | 12. CITIZEN OF WHAT COUNTRY?                 |
| HOUSEWIFE   |         |  |   |   | VA.                                       |  | U.S.A.                                       |
| 13. FATHER'S NAME   |         |  | 14. MOTHER'S MAIDEN NAME                            |   |   |  |  |
| THOMAS MORRIS   |         |  | EULA WIGGINS  |   |   |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |         |  | 16. SOCIAL SECURITY NO.                             |   | 17. INFORMANT                             |  | ADDRESS                                      |
| NO  |         |  |   |   | FRANK LEWIS                               |  | 3587 GARRETT                                 |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |         |  | CAUSE OF DEATH                                      |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  |         |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: |   |   |  | 20 MOS.                                      |
| ANTECEDENT CAUSES   |         |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                 |   |   |  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |         |  | (C) DUE TO, OR AS A CONSEQUENCE OF:                 |   |   |  |  |
| II  |         |  |   |   |   |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |         |  |   |   |   |  |  |
| 19A. DATE OF OPERATION  |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No)   |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
|   |         |  |   | NO.   |   |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |   |  |  |
|   |         |  |   |   |   |  |  |
| 21D. TIME OF INJURY (APPROX.)   |         | 21E. INJURY OCCURRED   |   | 21F. HOW DID INJURY OCCUR?  |   |  |  |
| (Month) (Day) (Year) (Hour)   |         | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |   |   |   |  |  |
| 22. I certify that (X) (this hospital) attended the deceased from 8-22 1968 to 1-25 1969, that (1) (we) last saw the deceased alive on 1-25 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. |         |  |   |   |   |  |  |
| 23A. SIGNATURE  |         |  |   | 23B. DATE SIGNED  |   |  |  |
| Irving L. Cooperstein   |         |  |   | 1-25-69   |   |  |  |
| 23C. PHYSICIAN'S NAME (Type)  |         |  |   | 23D. ADDRESS  |   |  |  |
| IRVING L. COOPERSTEIN   |         |  |   | MONTEBELLO HOSPITAL, BALTO. 21218   |   |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |         | 24B. DATE  |   | 24C. NAME OF CEMETERY or CREMATORY  |   | 24D. LOCATION (City, town, or county) (State)                        |  |
| BURIAL  |         | 1-29-69  |   | GARDEN OF ETERNAL HOPE  |   | FINKSBURG, Md.   |  |
| 25A. DATE REC'D BY HEALTH DEPT.   |         | 25B. NAME OF REGISTRAR   |   | 25C. FUNERAL DIRECTOR   |   | ADDRESS  |  |
| JAN 28 1969   |         | R. E. G. G. G.   |   | V. R. BAILEY  |   | 1348 CALHOUN ST  |  |



1  
C-514

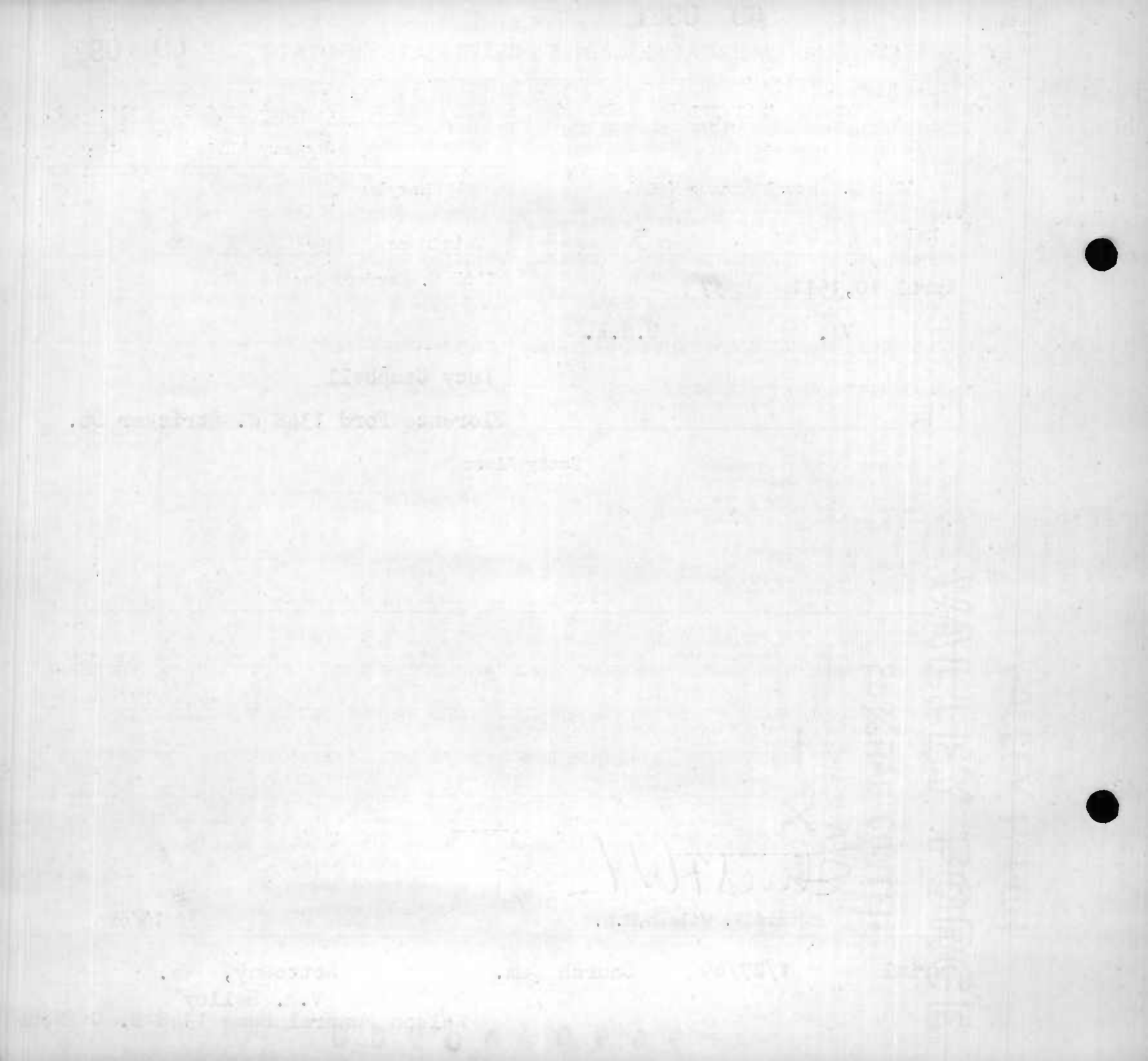
69 0981 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 0981

BIRTH NO.

|   |                  |   |  |
|---|------------------|---|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br>RICHARD CAMPBELL  |                  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> January 23, 1969<br>10:20 P.M.                      |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>1225 N. Central Avenue (DOA)  |                  | 3. DATE PRONOUNCED DEAD<br>Month Day Year<br>January 23, 1969<br>10:20 P.M.   |  |
| 6. SEX<br>Male  | 7. RACE<br>Negro | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. DATE OF BIRTH<br>April 10, 1911  |                  | 10. AGE (In years last birthday)<br>57  |  |
| 11. BIRTHPLACE (State or foreign country)<br>Va.  |                  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                  | 14B. KIND OF BUSINESS OR INDUSTRY   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, name or unknown) (If yes, give war or dates of service)<br>NO   |                  | 17. SOCIAL SECURITY NO.   |  |
| 15. MOTHER'S MAIDEN NAME<br>Lucy Campbell   |                  | 18. INFORMANT<br>Florence Ford 1348 N. Stricker St.   |  |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>Fatty Liver   |                  | CAUSE OF DEATH<br>Fatty Liver   |  |
| 20A. DATE OF OPERATION<br>2   |                  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.  |                  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?  |                  | 22D. TIME OF INJURY (APPROX.)   |  |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                  | 22F. HOW DID INJURY OCCUR?  |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE: [Signature] M.D.<br>EXAMINER'S NAME (Type): Edward F. Wilson, M.D.<br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED: 1/24/69 |                  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |                  | 24B. DATE<br>1/27/69  |  |
| 24C. NAME OF CEMETERY or CREMATORY<br>Church Cem.   |                  | 24D. LOCATION (City, town, or county) (State)<br>Nottoway, Va.  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>JAN 28 1969  |                  | 25B. NAME OF REGISTRAR<br>[Signature]   |  |
| 25C. FUNERAL DIRECTOR<br>V.R. Baliey  |                  | 25D. ADDRESS<br>Kelson Funeral Home 1348 N. Calhoun   |  |



# FUNERAL DIRECTOR: IMPORTANT

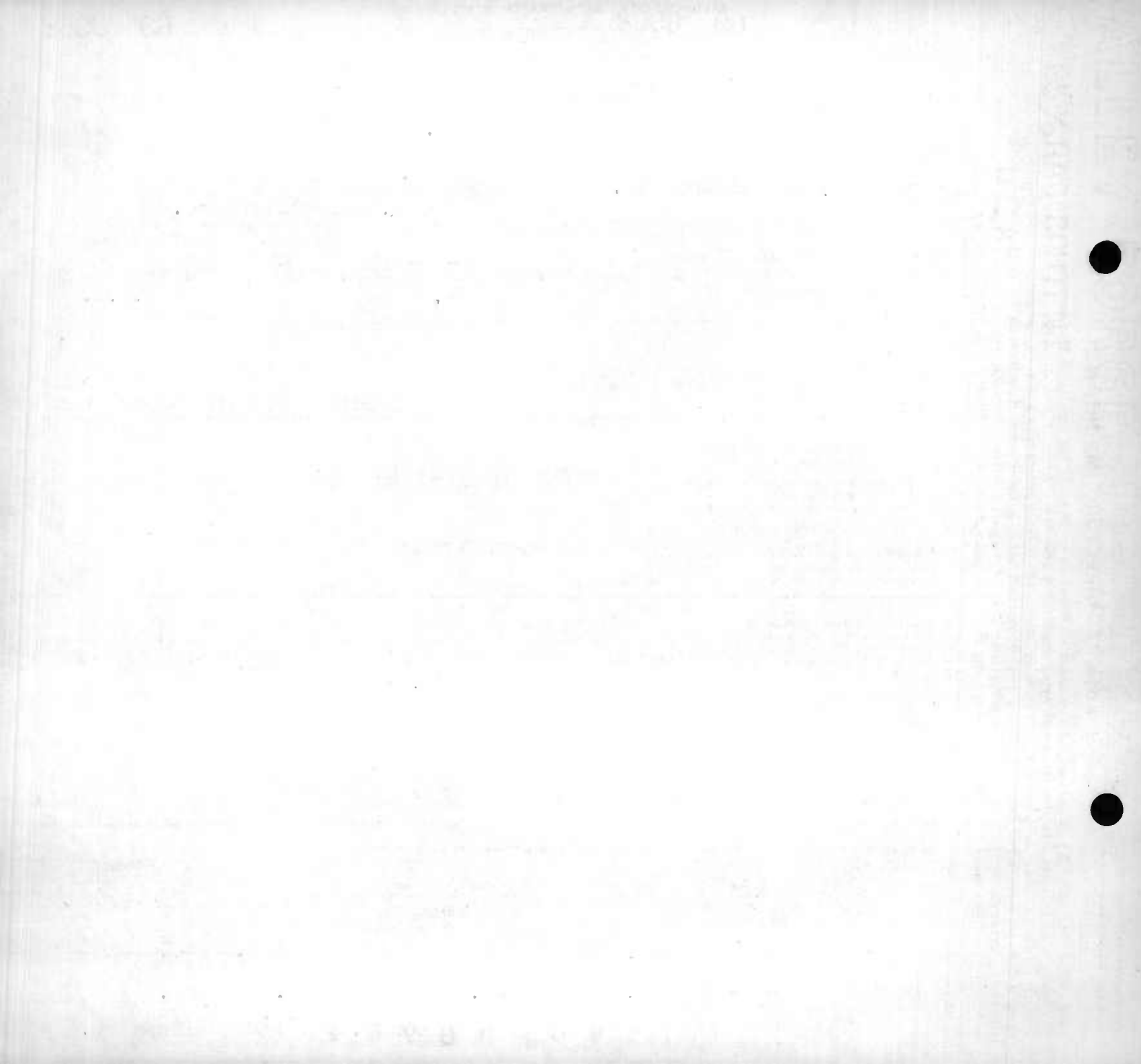
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0982

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 69 0982

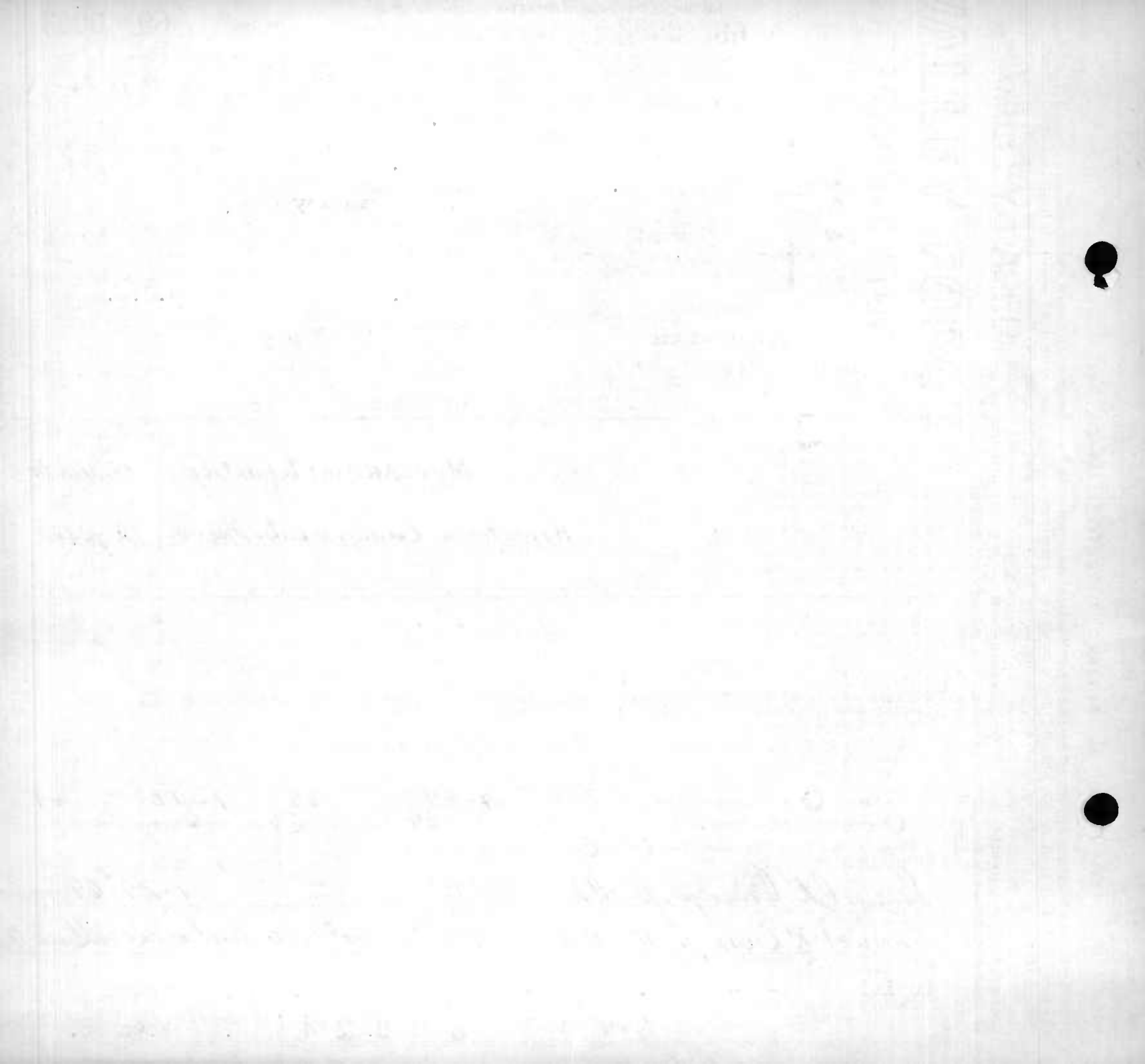
|  |  |   |  |   |  |
|--|--|---|--|---|--|
| BIRTH NO.  |  | 1. NAME OF DECEASED<br>(Type or Print)  |  | 2. DATE AND HOUR OF DEATH   |  |
|  |  | Henry Taylor  |  | 1-23-69   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)         |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |  |   |  | A. STATE<br>Md.   |  |
| 00 909 Carrollton Ave.   |  |   |  | B. COUNTY<br>16-01  |  |
| 5. SEX<br>Male   |  | 6. RACE<br>Negroid  |  | C. CITY OR TOWN<br>Balto.   |  |
|  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 8. DATE OF BIRTH<br>8-12-85  |  | 9. AGE (In years last birthday)<br>83   |  | E. STREET AND NUMBER<br>909 N. Carrollton Ave.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br>Va.  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 13. FATHER'S NAME   |  |   |  |
| 14. MOTHER'S MAIDEN NAME   |  | 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br>no   |  |   |  |
| 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>Cora Gladden   |  |   |  |
| ADDRESS<br>909 Carrollton Ave  |  |   |  |   |  |
| 18. CAUSE OF DEATH   |  |   |  |   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  |   |  |   |  |
| (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Cerebral Accident  |  |   |  |   |  |
| (B) Hyperextension - Cerebral Vess. Rupture<br>DUE TO, OR AS A CONSEQUENCE OF:   |  |   |  |   |  |
| (C)  |  |   |  |   |  |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>?  |  |   |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |  |   |  |   |  |
| 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)   |  |
| 0 none   |  |   |  | no  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 1-23-69 to Jan 23, 1969, and that (I) (we) lost saw the deceased alive on Jan 23, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                  |  |   |  |   |  |
| 23A. SIGNATURE<br>George McDonald  |  |   |  | 23B. DATE SIGNED<br>1/27/69   |  |
| 23C. PHYSICIAN'S NAME (Print)<br>George McDonald M.D.  |  |   |  | 23D. ADDRESS<br>844 N Carey St. Balt. Md.   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)  |  | 24B. DATE   |  | 24C. NAME OF CEMETERY or CREMATORY  |  |
| Burial   |  | 1-27-69   |  | Mt. Auburn Cem.   |  |
| 24D. LOCATION (City, town, or county)  |  | 24E. STATE  |  | 24F. ADDRESS  |  |
| Balto.   |  | Md.   |  | 1348 Calhoun St.  |  |
| 25A. DATE REC'D BY HEALTH DEPT.  |  | 25B. NAME OF REGISTRAR  |  | 25C. FUNERAL DIRECTOR   |  |
| JAN 28 1969  |  | V.R. Bailey   |  | Kelson B.H.   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |  |  |  | REG. NO.  | 69 0983 |
|--|--|--|--|---|---------|
| 69 0983  |  | CERTIFICATE OF DEATH   |  |   |         |
| BIRTH NO.  |  | 1. NAME OF DECEASED<br>(Type or Print) <b>Mary Thomas</b>  |  | 2. DATE AND HOUR OF DEATH<br><b>1-23-69 11:00 A.M.</b>  |         |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY |  | 18-01   |         |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>00</b>  |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>823 Saratoga St.</b>                        |  | C. CITY OR TOWN<br><b>alto.</b> D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |         |
| 5. SEX<br><b>Female</b>  |  | 6. RACE<br><b>Negroid</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |         |
| 8. DATE OF BIRTH<br><b>12-21-97</b>  |  | 9. AGE (In years last birthday) <b>71</b>  |  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.   |         |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>MD.</b>   |         |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 13. FATHER'S NAME<br><b>James Sims</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary</b>   |         |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>  |  | 16. SOCIAL SECURITY NO.<br><b>212149865</b>  |  | 17. INFORMANT<br><b>Ruth Thomas</b> ADDRESS<br><b>same</b>  |         |
| 18. <b>410-01</b>  |  | CAUSE OF DEATH   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |         |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) |  | (A) IMMEDIATE CAUSE<br><b>Myocardial Infarction</b>  |  | <b>15 minutes</b>   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (B) <b>Hypertensive Cardiovascular Disease</b>   |  | <b>2 years</b>  |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (C) _____  |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (D) _____  |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (E) _____  |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (F) _____  |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (G) _____  |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (H) _____  |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (I) _____  |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (J) _____  |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (K) _____  |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (L) _____  |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (M) _____  |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (N) _____  |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (O) _____  |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (P) _____  |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (Q) _____  |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (R) _____  |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (S) _____  |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (T) _____  |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (U) _____  |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (V) _____  |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (W) _____  |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (X) _____  |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (Y) _____  |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (Z) _____  |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (AA) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (AB) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (AC) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (AD) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (AE) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (AF) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (AG) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (AH) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (AI) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (AJ) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (AK) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (AL) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (AM) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (AN) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (AO) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (AP) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (AQ) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (AR) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (AS) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (AT) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (AU) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (AV) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (AW) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (AX) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (AY) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (AZ) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (BA) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (BB) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (BC) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (BD) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (BE) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (BF) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (BG) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (BH) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (BI) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (BJ) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (BK) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (BL) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (BM) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (BN) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (BO) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (BP) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (BQ) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (BR) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (BS) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (BT) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (BU) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (BV) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (BW) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (BX) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (BY) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (BZ) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (CA) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (CB) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (CC) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (CD) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (CE) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (CF) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (CG) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (CH) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (CI) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (CJ) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (CK) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (CL) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (CM) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (CN) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (CO) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (CP) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (CQ) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (CR) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (CS) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (CT) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (CU) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (CV) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (CW) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (CX) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (CY) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (CZ) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (DA) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (DB) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (DC) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (DD) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (DE) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (DF) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (DG) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (DH) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (DI) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (DJ) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (DK) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (DL) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (DM) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (DN) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (DO) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (DP) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (DQ) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (DR) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (DS) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (DT) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (DU) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (DV) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (DW) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (DX) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (DY) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (DZ) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (EA) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (EB) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (EC) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (ED) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (EE) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (EF) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (EG) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (EH) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (EI) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (EJ) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (EK) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (EL) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (EM) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (EN) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (EO) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (EP) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (EQ) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (ER) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (ES) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (ET) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (EU) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (EV) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (EW) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (EX) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (EY) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (EZ) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (FA) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (FB) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (FC) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (FD) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (FE) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (FF) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (FG) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (FH) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (FI) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (FJ) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (FK) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (FL) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (FM) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (FN) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (FO) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (FP) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (FQ) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (FR) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (FS) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (FT) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (FU) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (FV) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (FW) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (FX) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (FY) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (FZ) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (GA) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (GB) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (GC) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (GD) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (GE) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (GF) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (GG) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (GH) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (GI) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (GJ) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (GK) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (GL) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (GM) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (GN) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (GO) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (GP) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (GQ) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (GR) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (GS) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (GT) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (GU) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (GV) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (GW) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (GX) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (GY) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (GZ) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (HA) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (HB) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (HC) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (HD) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (HE) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (HF) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (HG) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (HH) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (HI) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (HJ) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (HK) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (HL) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (HM) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (HN) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (HO) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (HP) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (HQ) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (HR) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (HS) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (HT) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (HU) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (HV) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (HW) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (HX) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (HY) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (HZ) _____   |  |   |         |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | (IA) _____   |  |   |         |





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 69 0984  |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | CERTIFICATE OF DEATH  |  | REG. NO. 69 0984   |  |
| BIRTH NO.  |  |  |  | 1. NAME OF DECEASED<br>(Type or Print) <u>James Stewart</u>   |  |  |  |
| 2. DATE AND HOUR OF DEATH<br><u>1/23/69</u> <u>9:00 P.M.</u>   |  |  |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  |  |  |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>  |  |  |  | 5. SEX <u>Male</u> 6. RACE <u>N</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  |
| C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  | 8. DATE OF BIRTH <u>7-1-07</u> 9. AGE (In years last birthday) <u>61</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.  |  |  |  |
| E. STREET AND NUMBER <u>3012 Grantley Ave.</u>   |  |  |  | 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Consolidated Freight Co.</u> 10B. KIND OF BUSINESS OR INDUSTRY <u>Ga.</u> 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? |  |  |  |
| 13. FATHER'S NAME <u>James Stewart</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Claudia Fredericks</u>  |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>   |  |  |  | 16. SOCIAL SECURITY NO. <u>110-03-5836</u>  |  | 17. INFORMANT <u>Helen Stewart</u> ADDRESS <u>2125 Braddish Ave.</u>     |  |
| MEDICAL CERTIFICATION  |  |  |  | 18. CAUSE OF DEATH  |  |  |  |
|  |  |  |  | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  |  |  |  |
|  |  |  |  | ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  |  |  |
|  |  |  |  | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |  |  |  |
| 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No) <u>NO</u>   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?     |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |  |  |
| 22. I certify that (1) (this hospital) attended the deceased from <u>September 19 68</u> to <u>January 19 69</u> that (1) (we) last saw the deceased alive on <u>January 12 19 69</u> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) <u>did not</u> view the body after death. |  |  |  |   |  |  |  |
| 23A. SIGNATURE <u>Joseph Silva</u> DEGREE  |  |  |  | 23B. DATE SIGNED <u>1/27/69</u>   |  | 23C. PHYSICIAN'S NAME (Type) <u>Joseph Silva, M.D.</u> DEGREE            |  |
| 23D. ADDRESS <u>The Johns Hopkins Hospital</u>   |  |  |  |   |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 24B. DATE <u>1-28-69</u>   |  | 24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>   |  | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> |  |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 28 1969</u>   |  | 25B. NAME OF REGISTRAR <u>R. E. Taylor</u>   |  | 25C. FUNERAL DIRECTOR <u>V. R. Bailey</u> ADDRESS <u>Keyson Bldg. 31348 Calhoun St.</u>   |  |  |  |



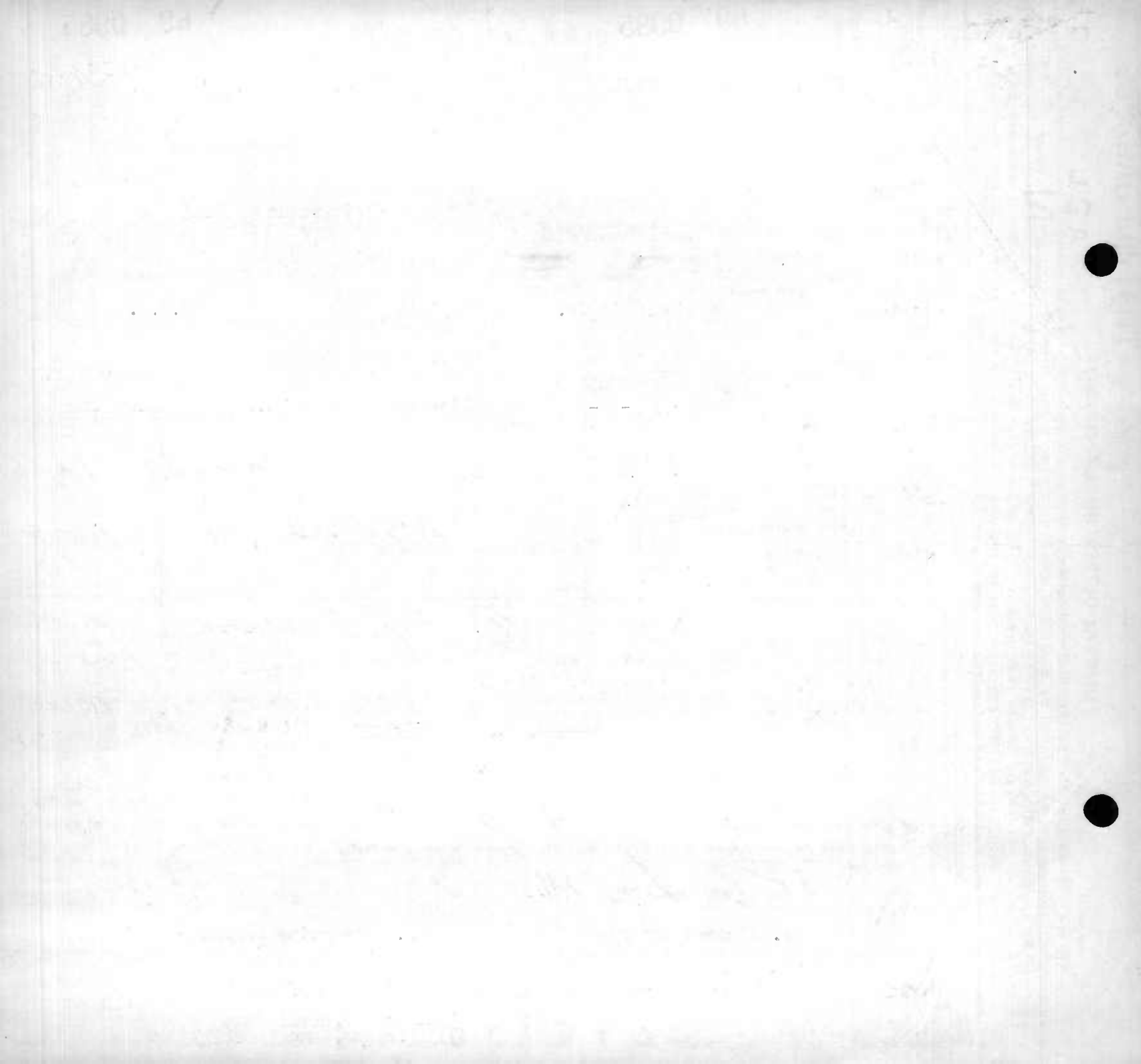
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BIRTH NO. 69 0985 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 69 0985

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| BIRTH NO.   |  | 1. NAME OF DECEASED<br>(Type or Print) <b>HITT, CHARLES LESLIE</b>   |  | 2. DATE AND HOUR OF DEATH<br><b>January 24, 1969   7<sup>30</sup> PM</b> M.   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>26-43</b>                              |  | C. CITY OR TOWN <b>Baltimore</b>  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>90 House of the Pines</b>  |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 5. SEX<br><b>male</b>   |  | 6. RACE<br><b>white</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH<br><b>May 16, 1883</b>   |  | 9. AGE (In years lost birthday)<br><b>85</b>   |  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Clerical</b>  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>American Oil Co.</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 13. FATHER'S NAME<br><b>Henry Hitt</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Alice Rucker</b>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.<br><b>218-05-3597</b>  |  | 17. INFORMANT<br><b>Alice Ebersole, dght., 3921 Dudley Avenue</b>   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>Cerebrovascular accident</b>                        |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>ASCVD</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>hip fracture</b><br>(C) <b>Months</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Days</b><br><b>Years</b>   |  |
| 19A. DATE OF OPERATION<br><b>OCTOBER 1968</b>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>FRACTURE - FEMUR</b>  |  | 20A. AUTOPSY? (Yes or No)<br><b>No</b>  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input checked="" type="checkbox"/>  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>HOME STREET</b>   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>DUDLEY AVE (HOME)</b>  |  |
| 21D. TIME OF INJURY (APPROX.)<br><b>at 4 1968 9<sup>15</sup> AM</b>   |  | 21E. INJURY OCCURRED<br>White At Work <input type="checkbox"/> Not White At Work <input checked="" type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?<br><b>SUBJECT FELL</b>   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>1-22-69</b> to <b>1-24-69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |   |  |
| 23A. SIGNATURE<br><b>Dr. Richard Gundry</b>   |  | 23B. DATE SIGNED<br><b>1-27-69</b>   |  | 23C. PHYSICIAN'S NAME (Type)<br><b>Dr. Richard Gundry</b>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>1/27/69</b>  |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Loudon Park Cemetery</b>   |  |
| 24D. LOCATION<br><b>Baltimore</b>   |  | 24E. CITY, TOWN, OR COUNTY<br><b>Maryland</b>  |  | 24F. STATE<br><b>Maryland</b>   |  |
| 25A. DATE RECEIVED BY HEALTH DEPT.<br><b>JAN 28 1969</b>  |  | 25B. NAME OF REGISTRAR<br><b>John E. Schuchman</b>   |  | 25C. FUNERAL DIRECTOR<br><b>Schimunek Funeral Home</b>  |  |
| 25D. ADDRESS<br><b>3330 Brehms Lane</b>   |  | 25E. ADDRESS<br><b>21213</b>   |  | 25F. ADDRESS<br><b>21213</b>  |  |



# FUNERAL DIRECTOR: IMPORTANT

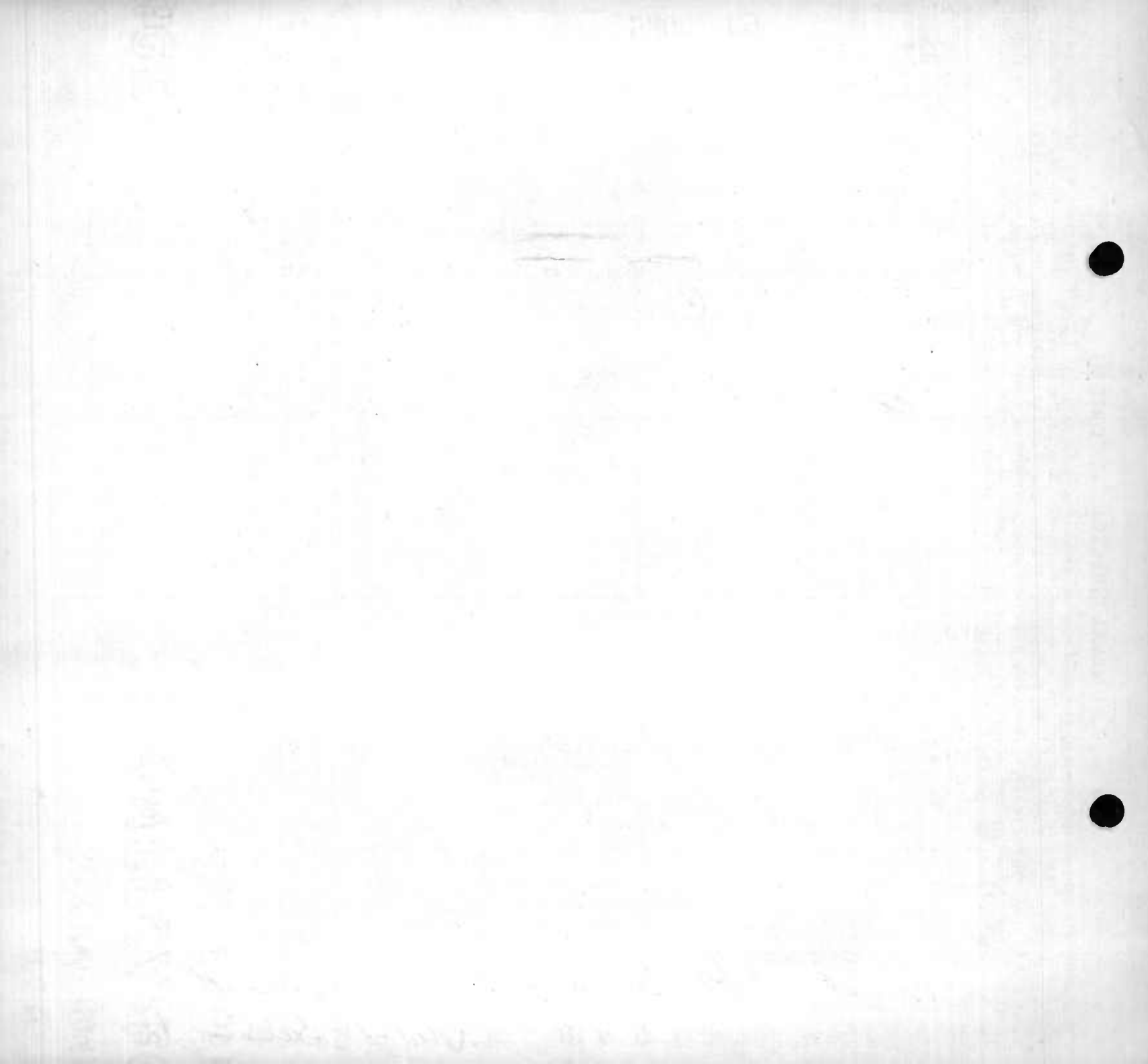
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## Baltimore City Health Department 69 0986 CERTIFICATE OF DEATH

REG. NO.

69 0986

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| BIRTH NO.  |  | 1. NAME OF DECEASED<br>(Type or Print)   |  | 2. DATE AND HOUR OF DEATH   |  |
|  |  | MARION TERESA DAHM   |  | 1-24-69 9:00 A.M.   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |  |
|  |  |  |  | A. STATE B. COUNTY  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |  |  |  | C. CITY OR TOWN   |  |
| LITTLE SISTERS OF THE POOR   |  |  |  | D. INSIDE CITY LIMITS?  |  |
|  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                   |  |
| 5. SEX   |  |  |  | E. STREET AND NUMBER  |  |
| F  |  |  |  | 1200 VALLEY ST.   |  |
| 6. RACE  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>    |  | 8. DATE OF BIRTH  |  |
| W  |  | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>            |  | 12-5-1890 78  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 9. AGE (In years last birthday)   |  |
| HOUSEWIFE  |  | @ home   |  | BALTIMORE, MD.  |  |
| 13. FATHER'S NAME  |  |  |  | 12. CITIZEN OF WHAT COUNTRY?  |  |
| NAPOLEON HARDING   |  |  |  | U.S.A.  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |  |  |  | 14. MOTHER'S MAIDEN NAME  |  |
| No   |  |  |  | TERESA DARCEY   |  |
| 16. SOCIAL SECURITY NO.  |  |  |  | 17. INFORMANT   |  |
| 215-09-4204  |  |  |  | Sister George, Sup.   |  |
| 18. CAUSE OF DEATH   |  |  |  | ADDRESS   |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH   |  |  |  | 1200 VALLEY ST., BALTIMORE, MD.   |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| ANTECEDENT CAUSES  |  |  |  | (A) IMMEDIATE CAUSE   |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF:   |  |
|  |  |  |  | C. V. A.  |  |
|  |  |  |  | (B) Severe Q. S. Brain deterioration  |  |
|  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF:   |  |
|  |  |  |  | (C) ...   |  |
| II   |  |  |  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |  |  |   |  |
| 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)   |  |
| 0  |  |  |  |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |  |
|  |  |  |  |   |  |
| 21D. TIME OF INJURY (APPROX.)  |  | 21E. INJURY OCCURRED   |  | 21F. HOW DID INJURY OCCUR?  |  |
| (Month) (Day) (Year) (Hour)  |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from 1968 to Jan 24 1969, that (I) (we) last saw the deceased alive on Jan 24 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |   |  |
| 23A. SIGNATURE   |  |  |  | 23B. DATE SIGNED  |  |
| Stanley Ankudis  |  |  |  | 1.24.69   |  |
| 23C. PHYSICIAN'S NAME (Type)   |  |  |  | 23D. ADDRESS  |  |
| DR. STANLEY ANKUDAS MD.  |  |  |  | 1101 MAIDEN CHOICE LANE   |  |
|  |  |  |  | BALTIMORE, MD. 21229  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |  | 24B. DATE  |  | 24C. NAME OF CEMETERY OR CREMATORY  |  |
| Burial   |  | 1/28/69  |  | Druid Ridge   |  |
| 25A. DATE REC'D BY HEALTH DEPT.  |  | 25B. NAME OF REGISTRAR   |  | 25C. FUNERAL DIRECTOR   |  |
| JAN 28 1969  |  | R. J. ...  |  | Shelby S. Baranov, Severna Park, Md.  |  |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

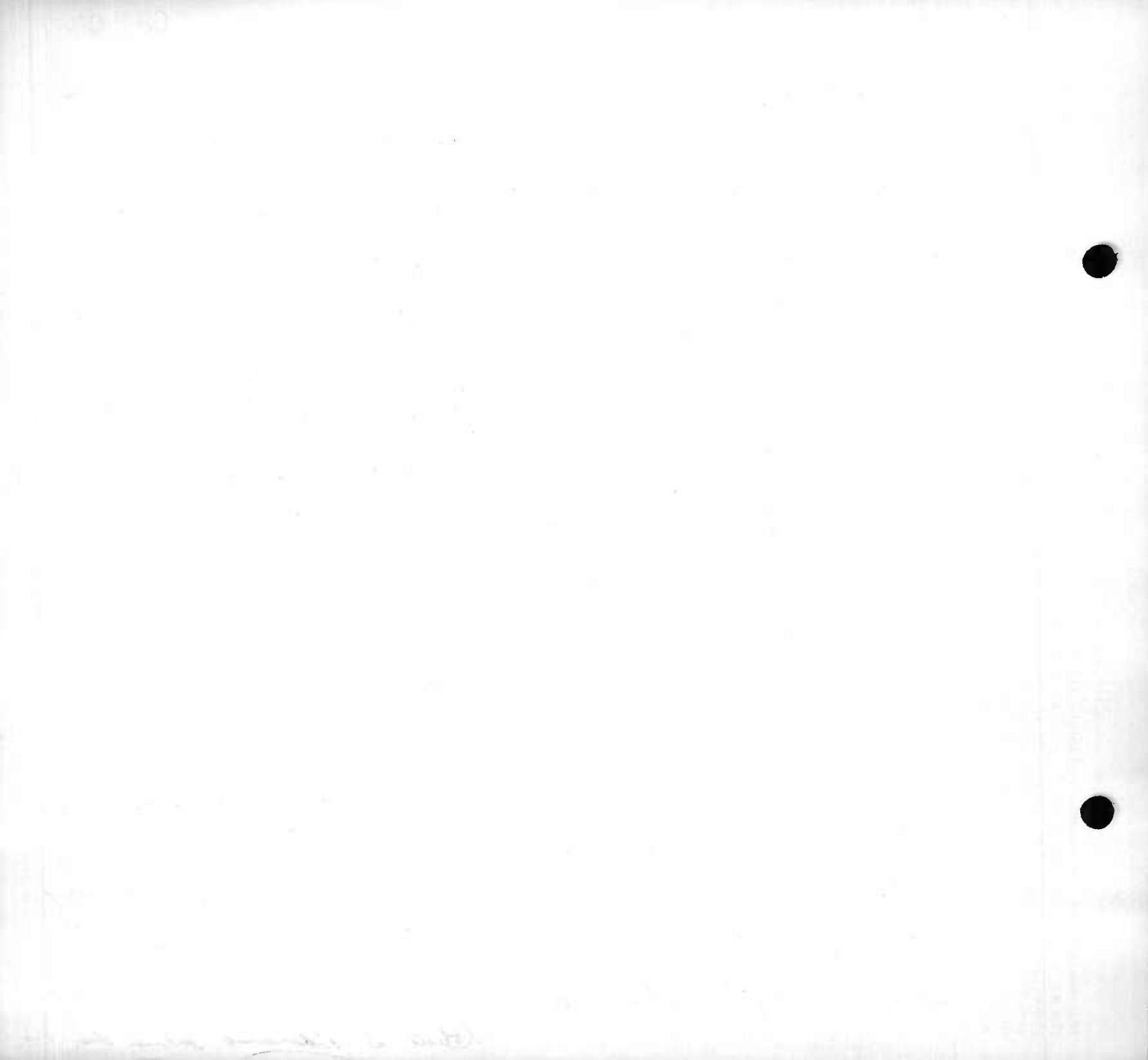
BALTIMORE CITY HEALTH DEPARTMENT

69 0987 CERTIFICATE OF DEATH

REG. NO.

69 0987

|   |  |   |  |
|---|--|---|--|
| BIRTH NO.   |  | 69 0987   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Dorothy Anderson</i>  |  | 2. DATE AND HOUR OF DEATH<br><i>23 JAN 1969 11 10 P.M.</i>  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY <i>Anne Arundel</i>             |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><i>Sinai Hospital of Baltimore</i>   |  | C. CITY OR TOWN <i>Pasadena</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                  |  |
| E. STREET AND NUMBER<br><i>Waterford Rd, Box 84, Rt 4</i>   |  |   |  |
| 5. SEX <i>Female</i>  | 6. RACE <i>Cauc.</i>                         | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>12/2/01</i>  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>@ home</i>  | 9. AGE (in years last birthday) <i>67</i>                              |
| 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  |
| 13. FATHER'S NAME<br><i>Henry Linch</i>   |  | 14. MOTHER'S MAIDEN NAME<br><i>Mary Robbly</i>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>No</i>   |  | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><i>Edmund Anderson - Above</i>   |  | ADDRESS   |  |
| 18. <i>89.0</i> I   |  | CAUSE OF DEATH  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>CANCER of KIDNEY</i>   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  | (B) DUE TO, OR AS A CONSEQUENCE OF:   |  |
| (C)   |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |   |  |
| 19A. DATE OF OPERATION<br><i>0</i>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20A. AUTOPSY? (Yes or No)<br><i>No</i>  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examined)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |   |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  |
| 21F. HOW DID INJURY OCCUR   |  |   |  |
| 22. I certify that <i>My</i> (this hospital) attended the deceased from <i>5 JAN 1969</i> to <i>23 JAN 1969</i> that <i>My</i> (we) last saw the deceased alive on <i>23 JAN 1969</i> and that <i>My</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>My</i> (We) (did) <i>view</i> the body after death. |  |   |  |
| 23A. SIGNATURE<br><i>Monis Ostroff, MD</i>  |  | 23B. DATE SIGNED<br><i>23 JAN 69</i>  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><i>Monis Ostroff, MD</i>  |  | 23D. ADDRESS<br><i>Sinai Hospital of Balt.</i>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  | 24B. DATE<br><i>1/27/69</i>                  | 24C. NAME of CEMETERY or CREMATORY<br><i>Glen Haven Cem</i>   | 24D. LOCATION (City, lawn, or county) (State)<br><i>Glen Burnie Md</i> |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>JAN 28 1969</i>   | 25B. NAME OF REGISTRAR<br><i>R. J. J. J.</i> | 25C. FUNERAL DIRECTOR<br><i>Robert J. J. J.</i>   | ADDRESS<br><i>1000 N. ...</i>  |





# FUNERAL DIRECTOR: IMPORTANT

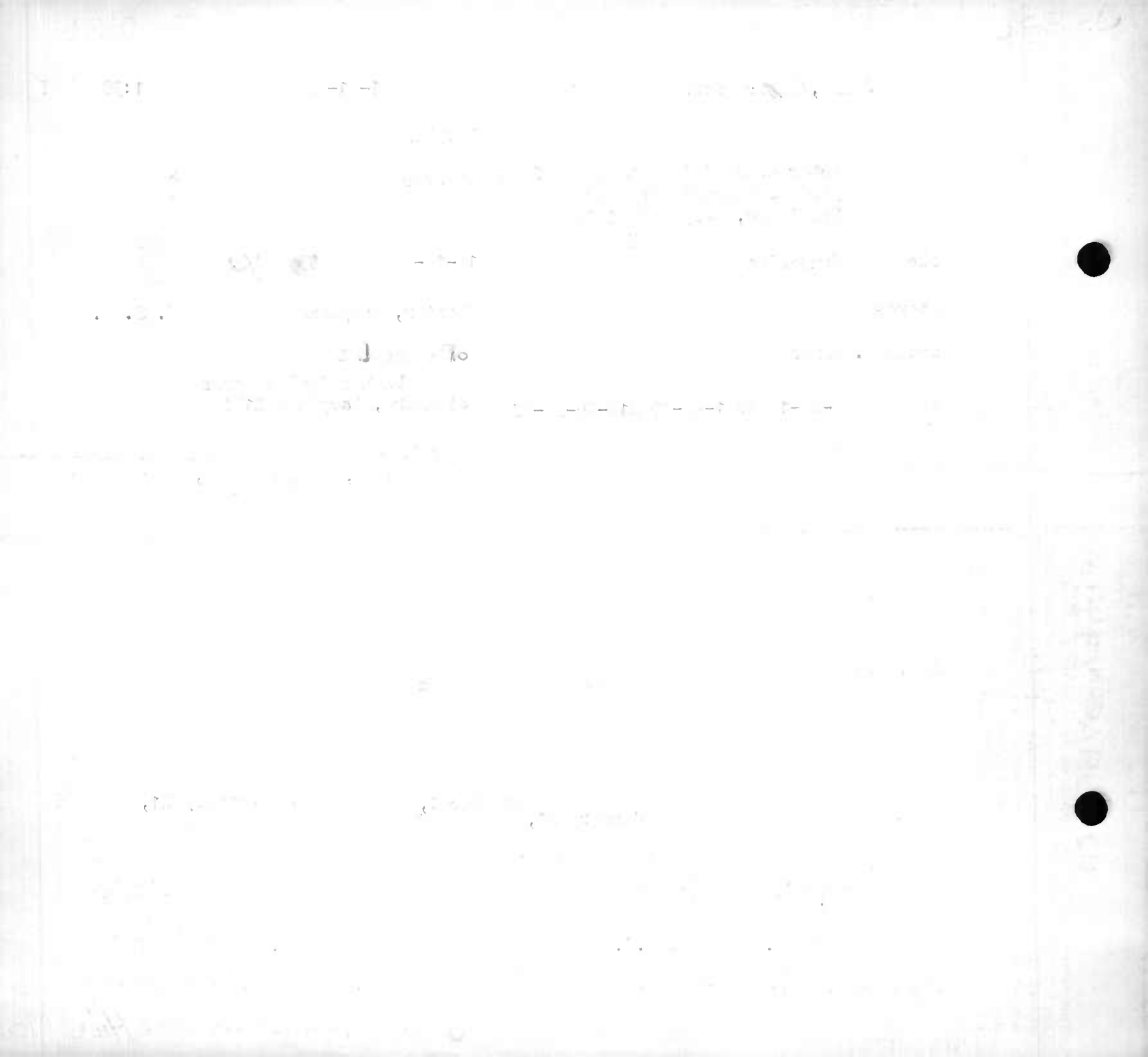
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0988

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 69 0988

|  |                             |   |                                     |  |   |
|--|-----------------------------|---|-------------------------------------|--|---|
| BIRTH NO.  |                             | 1. NAME OF DECEASED<br>(Type or Print) <b>JONES, Edgar Owens</b>  |                                     | 2. DATE AND HOUR OF DEATH<br><b>1-21-69 1:30 P.M.</b>  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>Queen Anne's 67-00</b>    |                                     | C. CITY OR TOWN <b>Chester</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>23 Veterans Administration Hospital<br/>3900 Loch Raven Boulevard<br/>Baltimore, Maryland 21218</b>   |                             | E. STREET AND NUMBER  |                                     |  |   |
| 5. SEX<br><b>Male</b>  | 6. RACE<br><b>Caucasian</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12-14-96</b> | 9. AGE (In years last birthday)<br><b>72</b>   | 10. Under 1 Yr. Months Days<br>11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Waterman</b>   |                             | 10B. KIND OF BUSINESS OR INDUSTRY   |                                     | 11. BIRTHPLACE (State or foreign country)<br><b>Chester, Maryland</b>  |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |                             | 13. FATHER'S NAME<br><b>Samuel W. Jones</b>   |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Lottie Needles</b>  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes 8-28-18 to 1-25-19</b>  |                             | 16. SOCIAL SECURITY NO.<br><b>214-20-38-23</b>  |                                     | 17. INFORMANT <b>VA Hospital Records</b><br><b>Baltimore, Maryland 21218</b>   |   |
| 18. <b>1610 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Carcinoma of vocal cord, squamous cell, invasive</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(A) IMMEDIATE CAUSE<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>greater than 3 months</b>  |                                     |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                             |   |                                     |  |   |
| 19A. DATE OF OPERATION<br><b>10/16/68</b>  |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>hoarsness</b>  |                                     | 20A. AUTOPSY? (Yes or No)<br><b>No</b>   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)   |                                     | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                             | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                     | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (X) (this hospital) attended the deceased from <b>October 1, 19 68</b> to <b>January 21, 19 69</b> that (X) (we) last saw the deceased alive on <b>January 21, 19 69</b> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) <b>not</b> view the body after death.   |                             |   |                                     |  |   |
| 23A. SIGNATURE<br><b>George W. Gaffney</b>   |                             | 23B. DATE SIGNED<br><b>1/22/69</b>  |                                     | 23C. PHYSICIAN'S NAME (Type)<br><b>GEORGE W. GAFFNEY, M.D.</b>   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                             | 24B. DATE<br><b>JAN. 24</b>   |                                     | 24C. NAME of CEMETERY or CREMATORY<br><b>STEVENSVILLE</b>  |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>STEVENSVILLE MARYLAND</b>  |                             | 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 28 1969</b>   |                                     | 25B. NAME OF REGISTRAR<br><b>R. A. S. S. S.</b>  |   |
| 25C. FUNERAL DIRECTOR<br><b>Edgar L. LANE-CHURCH HILL MD.</b>  |                             | 25D. ADDRESS  |                                     |  |   |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 69 0989

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*Brown, Charles.*

2. DATE AND HOUR OF DEATH

*1/23/69 11:05 P.M.*

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

*46 Lutheran Hosp. of Md.*

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

*Md.*

C. CITY OR TOWN  
*Balto.*

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

*510 Poplar Grove St.*

5. SEX

*M*

6. RACE

*N.*

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

*3-27-07*

9. AGE (In years last birthday)

*61*

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Unemp.*

10B. KIND OF BUSINESS OR INDUSTRY

*—*

11. BIRTHPLACE (State or foreign country)

*Md.*

12. CITIZEN OF WHAT COUNTRY?

*U.S.A.*

13. FATHER'S NAME

*Albert Brown*

14. MOTHER'S MAIDEN NAME

*Maggie Robertson*

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

*No*

16. SOCIAL SECURITY NO.

*— ?*

17. INFORMANT

ADDRESS

*Mrs. Mollie Costley Heneyton, Md.*

18.

*410.9 I*

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

*Acute Coronary insufficiency  
& myocardial infarction*

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) \_\_\_\_\_

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

*0*

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

*N.O.*

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from *1/20* 19 *69* to *1/23* 19 *69*, that (I) (we) last saw the deceased alive on *11:05 PM 1/23* 19 *69* and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

*H. L. Park M.D.*

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type)

*Hyung Kyoun Park M.D.*

23D. ADDRESS

*730 Ashburton St. Baltimore. 21216*

24A. BURIAL CREMATION REMOVAL (Specify)

*Burial*

24B. DATE

*1-27-69*

24C. NAME OF CEMETERY or CREMATORY

*West Liberty Cemetery*

24D. LOCATION

(City, town, or county)

*Howard Co. Md.*

(State)

25A. DATE REC'D BY HEALTH DEPT.

*JAN 28 1969*

25B. NAME OF REGISTRAR

*02265 E. Baltimore*

25C. FUNERAL DIRECTOR

*Harry W. Haight Sykesville, Md.*

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 69 0990 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 69 0990

|   |                         |   |                                    |  |   |
|---|-------------------------|---|------------------------------------|--|---|
| BIRTH NO.   |                         | 1. NAME OF DECEASED<br>(Type or Print) <i>Lillian M. Rottman</i>  |                                    | 2. DATE AND HOUR OF DEATH<br><i>1/25/69 10:30 A.M.</i>                                     |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                         | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY <i>21-02</i>  |                                    | C. CITY OR TOWN <i>Baltimore</i>   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><i>926 Washington Blvd.</i>  |                         | E. STREET AND NUMBER<br><i>926 Washington Blvd.</i>   |                                    | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 5. SEX<br><i>Female</i>   | 6. RACE<br><i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><i>3/14/91</i> | 9. AGE (in years last birthday)<br><i>77</i>   | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>   |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Own Home</i>  |                                    | 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>                               |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |                         | 13. FATHER'S NAME<br><i>John Mansdorfer</i>   |                                    | 14. MOTHER'S MAIDEN NAME<br><i>Unknown</i>   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>No</i>   |                         | 16. SOCIAL SECURITY NO.   |                                    | 17. INFORMANT<br><i>Joseph F. Rottman</i>  |   |
| 18. <i>75701</i> CAUSE OF DEATH   |                         | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><i>Carcinoma Head of Pancreas</i> |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>6 mo.</i>                               |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                         | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><i>Pancreas</i>  |                                    | (B) DUE TO, OR AS A CONSEQUENCE OF:  |   |
| (C) _____   |                         | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><i>Hypertensive Cardiovascular Disease 5 yrs</i>  |                                    |  |   |
| 19A. DATE OF OPERATION<br><i>0</i>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                    | 20A. AUTOPSY? (Yes or No)  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                         | 21B. PLACE OF INJURY (a.g., in or about home, farm, factory, street, office bldg., etc.)  |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                   |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                    | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>Jan 17 1969</i> to <i>Jan 25 1969</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>Jan 25 1969</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) (did not) view the body after death. |                         |   |                                    |  |   |
| 23A. SIGNATURE<br><i>A. Bradley Daugherty MD</i>  |                         | 23B. DATE SIGNED<br><i>1-26-69</i>  |                                    | 23C. PHYSICIAN'S NAME (Type)<br><i>Dr. A. Bradley Daugherty</i>                            |   |
| 23D. ADDRESS<br><i>1264 Francis Ave. Balto. Md. 21227</i>   |                         | 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                                    | 24B. DATE<br><i>1/29/69</i>  |   |
| 24C. NAME OF CEMETERY or CREMATORY<br><i>Meadow Ridge Cemetery</i>  |                         | 24D. LOCATION (City, town, or county) (State)<br><i>Dorsey, Maryland</i>  |                                    | 25A. DATE REC'D BY HEALTH DEPT.<br><i>JAN 28 1969</i>                                      |   |
| 25B. NAME OF REGISTRAR<br><i>Robert E. Jenkins</i>  |                         | 25C. FUNERAL DIRECTOR<br><i>Conover Inc.</i>  |                                    | 25D. ADDRESS<br><i>1328 Sulphur Sp Rd.</i>   |   |

Chief of Police Washington  
D. C. 20535

Joseph E. Rotten Washington

Unknown

Mark and

U. S. A.

John Marshall

Unknown

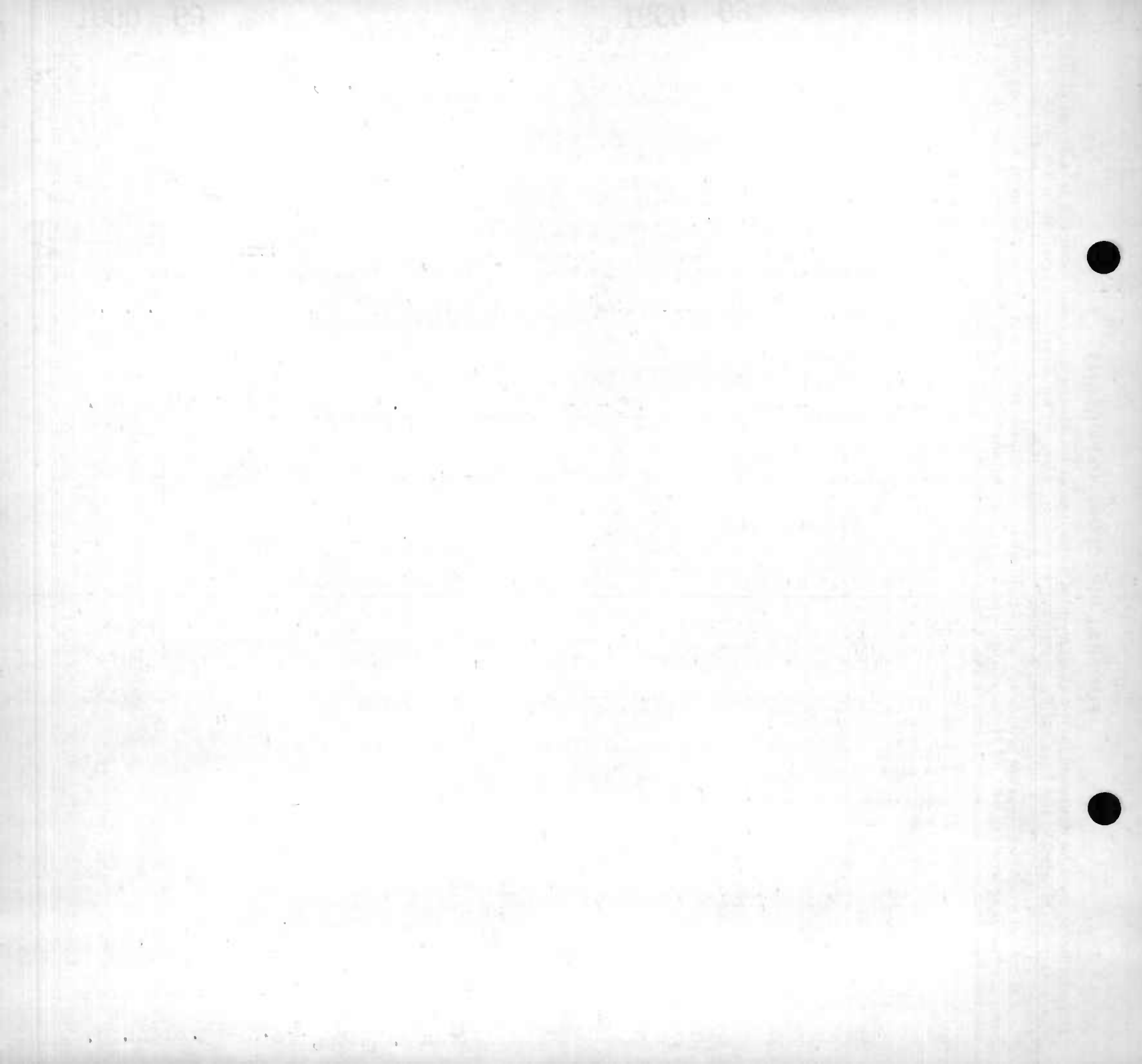
Female white

Washington D. C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                         |  |  | REG. NO. <span style="font-size: 1.5em;">69 0991</span>                                       |   |
|---|-------------------------|--|--|---|---|
| <div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">R-1631</span> <span style="font-size: 1.5em;">69 0991</span> <span style="font-size: 1.5em;">CERTIFICATE OF DEATH</span> </div>  |                         |  |  |   |   |
| BIRTH NO.   |                         | 1. NAME OF DECEASED<br>(Type or Print) <u>David Walter Rafferty</u>  |  | 2. DATE AND HOUR OF DEATH<br><u>Jan. 23, 1969</u> <span style="float: right;">425P.</span>    |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                         | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>Maryland</u><br>B. COUNTY <u>27-34</u>  |  |   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>90 Goulds Convalesarium</u>  |                         | C. CITY OR TOWN<br><u>Baltimore</u>  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |                         | E. STREET AND NUMBER<br><u>6776 Belair Road</u>  |  |   |   |
| 5. SEX<br><u>Male</u>   | 6. RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | B. DATE OF BIRTH<br><u>May 9, 1889</u> | 9. AGE (In years lost birthday) <u>79</u> <del>80</del>                                       | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Accountant (retired)</u>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>                                  |   |
| 13. FATHER'S NAME<br><u>John Rafferty</u>   |                         | 14. MOTHER'S MAIDEN NAME<br><u>unknown</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>-----</u>  |                         | 16. SOCIAL SECURITY NO.<br><u>215-09-3075</u>  |  | 17. INFORMANT<br><u>Joseph A. Rafferty</u>  |   |
|   |                         |  |  | ADDRESS<br><u>1221 Evesham Ave.</u>   |   |
| 18. <u>412.4</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                         | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br><u>Acute pulmonary edema</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <u>Arteriosclerotic C-V disease</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <u>associated Peripheral vasospasm</u> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 Day</u><br><u>20 yrs</u>                 |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                         |  |  |   |   |
| 19A. DATE OF OPERATION<br><u>0</u>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notably medical examiner)  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |   |
| 21D. TIME OF INJURY (APPROX.)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Jan. 18 1968</u> to <u>Jan 23 1969</u> , that (I) (we) last saw the deceased alive on <u>Jan 23 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                  |                         |  |  |   |   |
| 23A. SIGNATURE<br><u>H. V. Harbold M.D.</u>   |                         |  |  | 23B. DATE SIGNED<br><u>Jan. 24 1969</u>   |   |
| 23C. PHYSICIAN'S NAME (Type)<br><u>H. V. Harbold M.D.</u>   |                         |  |  | 23D. ADDRESS<br><u>4706 Harford Road Baltimore Md.</u>  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                         | 24B. DATE<br><u>1/27/69</u>  |  | 24C. NAME OF CEMETERY or CREMATORY<br><u>New Cathedral Cemetery</u>                           |   |
| 24D. LOCATION<br><u>Baltimore</u>   |                         | 24E. LOCATION<br><u>Maryland</u>   |  |   |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>JAN 28 1969</u>   |                         | 25B. NAME OF REGISTRAR<br><u>John A. Moran</u>   |  | 25C. FUNERAL DIRECTOR<br><u>Inc. 3000 E. Balto. St.</u>                                       |   |





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 69 0992 CERTIFICATE OF DEATH

REG. NO. 69 0992

|  |         |   |                          |   |   |
|--|---------|---|--------------------------|---|---|
| BIRTH NO.  |         | 1. NAME OF DECEASED<br>(Type or Print)  |                          | 2. DATE AND HOUR OF DEATH   |   |
|  |         | MEYER, MARIE JANE   |                          | 1-26-69 1:20 A.M.   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |         |   |                          | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE B. COUNTY |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |         |   |                          | C. CITY OR TOWN D. INSIDE CITY LIMITS?  |   |
| 36 Franklin Square Hosp  |         |   |                          | Maryland 21-01<br>Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |   |
| E. STREET AND NUMBER   |         |   |                          | 1118 Sterrett St (21230)  |   |
| 5. SEX   | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH         | 9. AGE (In years last birthday)   | 10. BIRTHPLACE (State or foreign country) |
| F  | white   |   | 3-3-18                   | 50  | Maryland                                  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |         | 10B. KIND OF BUSINESS OR INDUSTRY   |                          | 12. CITIZEN OF WHAT COUNTRY?  |   |
| operator   |         | Federal Gov   |                          | U.S.A.  |   |
| 13. FATHER'S NAME  |         |   | 14. MOTHER'S MAIDEN NAME |   |   |
| HERMAN MEYER   |         |   | LAURA DEAYER             |   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |         | 16. SOCIAL SECURITY NO.   |                          | 17. INFORMANT ADDRESS   |   |
| no   |         | 214-01-5560   |                          | Franklin Square Hosp  |   |
| 18. CAUSE OF DEATH   |         |   |                          |   |   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH   |         |   |                          |   |   |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)   |         |   |                          |   |   |
| ANTECEDENT CAUSES  |         |   |                          |   |   |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |         |   |                          |   |   |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: sepsis pan-peritonitis   |         |   |                          |   |   |
| (B) DUE TO, OR AS A CONSEQUENCE OF: ruptured aortic aneurysm   |         |   |                          |   |   |
| (C) _____  |         |   |                          |   |   |
| II   |         |   |                          |   |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |         |   |                          |   |   |
| 19A. DATE OF OPERATION   |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                          | 20A. AUTOPSY? (Yes or No)   |   |
| 1-22-69  |         | perforated colon  |                          | NO  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                          | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                    |   |
|  |         |   |                          |   |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |         | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>  |                          | 21F. HOW DID INJURY OCCUR?  |   |
|  |         |   |                          |   |   |
| 22. I certify that (I) (this hospital) attended the deceased from 1-22-69 19 to 1-26 19 69, that (I) (we) last saw the deceased alive on 1-26 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |   |                          |   |   |
| 23A. SIGNATURE   |         |   |                          | 23B. DATE SIGNED  |   |
| Sungbok Lee  |         |   |                          | 1-26-69   |   |
| 23C. PHYSICIAN'S NAME (Type)   |         |   |                          | 23D. ADDRESS  |   |
| Sung Bok Lee   |         |   |                          | F. S. H. Calhoun + Fayette Sts  |   |
| 24A. BURIAL CREMATION REMOVAL (Specify)  |         | 24B. DATE   |                          | 24C. NAME OF CEMETERY or CREMATORY  |   |
| Burial   |         | 1/29/69   |                          | Int. Olivet Cemetery  |   |
| 25A. DATE REC'D BY HEALTH DEPT.  |         | 25B. NAME OF REGISTRAR  |                          | 25C. FUNERAL DIRECTOR ADDRESS   |   |
| JAN 28 1969  |         | D. S. H. Calhoun  |                          | 901 Hollins St. Balt. Md  |   |

●

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 0993 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 69 0993

|   |  |   |  |  |   |
|---|--|---|--|--|---|
| BIRTH NO.   |  | 1. NAME OF DECEASED<br>(Type or Print) <b>BAUMAN, JOSEPH</b>  |  | 2. DATE AND HOUR OF DEATH<br><b>1-26-69</b> <b>8 15 P M.</b>             |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD</b> B. COUNTY <b>23-02</b> |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>BOLTON HILL NURSING HOME</b><br><b>90</b>  |  |   | C. CITY OR TOWN<br><b>BALTIMORE</b>  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX <b>M</b> 6. RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |   | 8. DATE OF BIRTH<br><b>8-13-1882</b>   |  | 9. AGE (In years lost birthday) <b>86</b>   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>WATCHMAN</b>  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Weyerhaeuser</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>MD.</b>                  |   |
| 13. FATHER'S NAME<br><b>PAUL</b>  |  |   | 14. MOTHER'S MAIDEN NAME<br><b>MARGARET Seibold</b>  |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |  | 16. SOCIAL SECURITY NO.<br><b>212-12-7105</b>   |  | 17. INFORMANT<br><b>BOLTON HILL NURSING HOME</b>                         |   |
|   |  |   |  | ADDRESS<br><b>1400 JOHN ST.</b>  |   |
| 18. <b>4123 I</b> CAUSE OF DEATH  |  |   |  |  |   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  |   | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>cardiac degeneration and atherosclerosis</b>                          |  |   |
|   |  |   | (B) <b>arteriosclerotic heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>years</b>                                       |  |   |
|   |  |   | (C) <b>coronary atherosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>years</b>   |  |   |
| <b>II</b>   |  |   |  |  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |   |  |  |   |
| 19A. DATE OF OPERATION<br><b>0</b>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>1/17</b> 19 <b>69</b> to <b>1/26</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>1/26</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |  |  |   |
| 23A. SIGNATURE<br><b>ALAN H. MAECHT</b>   |  |   |  | 23B. DATE SIGNED<br><b>1/27/69</b>                                       |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>ALLAN H. MAECHT MD</b>   |  |   |  | 23D. ADDRESS<br><b>2 E. READ ST BALTIMORE MD 21202</b>                   |   |
| 24A. BURIAL CREMATION REMOVAL (Specify)<br><b>15</b>  |  | 24B. DATE<br><b>1/29/69</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill</b>                  |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore</b>   |  |   |  |  |   |
| 25A. DATE REC'D BY HEALTH DEPT.   |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Jenkins</b>  |  | 25C. FUNERAL DIRECTOR<br><b>130 E. FORT LEE</b>                          |   |
| 25D. ADDRESS  |  |   |  |  |   |

1871  
1872  
1873

1874

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 8212   |                         |   |                                    | BALTIMORE CITY HEALTH DEPARTMENT   |  |                              |  | REG. NO. 69 0994  |  |  |  |
|--|-------------------------|---|------------------------------------|--|--|------------------------------|--|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>BUKOVSKY, JEROME PAUL</b>  |                         |   |                                    | 2. DATE AND HOUR OF DEATH<br><b>JAN 26, 1969</b>   <b>12<sup>15</sup></b> <b>A</b> M.  |  |                              |  |   |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                         |   |                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE Co</b> |  |                              |  | 53-00   |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>BALTIMORE CITY HOSPITALS</b><br><b>314940 EASTERN AVENUE</b><br><b>BALTIMORE, MARYLAND 21224</b>   |                         |   |                                    | C. CITY OR TOWN<br><b>Dundalk</b>  |  |                              |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| E. STREET AND NUMBER<br><b>7857 KAVANAGH ROAD 21222</b>  |                         |   |                                    |  |  |                              |  |   |  |  |  |
| 5. SEX<br><b>MALE</b>  | 6. RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>7-11-09</b> | 9. AGE (In years lost birthday)<br><b>59</b>   | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Hours: Min. |  |   |  |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Management</b>   |                         |   |                                    | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Bethlehem Steel Co.</b>  |  |                              |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                  |  |  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |                         |   |                                    |  |  |                              |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>JOSEF BUKOVSKY</b>   |                         |   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>MARIE SIXTA</b>   |  |                              |  |   |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                         |   |                                    | 16. SOCIAL SECURITY NO.<br><b>214-01-3889</b>  |  |                              |  | 17. INFORMANT ADDRESS<br><b>BCH: RECORDS 4940 EASTERN AVE. BALTO. MD.</b>                     |  |  |  |
| 18. CAUSE OF DEATH<br><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. |                         |   |                                    | (A) IMMEDIATE CAUSE<br><b>CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF:  |  |                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| (B) <b>MASSIVE BRAIN INFARCT</b><br>DUE TO, OR AS A CONSEQUENCE OF:  |                         |   |                                    | (C) _____  |  |                              |  |   |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                         |   |                                    |  |  |                              |  |   |  |  |  |
| 19A. DATE OF OPERATION<br><b>1/24/69</b>   |                         |   |                                    | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>TRACHEOSTOMY</b>  |  |                              |  | 20A. AUTOPSY? (Yes or No)<br><b>YES</b>   |  |  |  |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b>   |                         |   |                                    |  |  |                              |  |   |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                         |   |                                    | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  |                              |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |  |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                         |   |                                    | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  |                              |  | 21F. HOW DID INJURY OCCUR?  |  |  |  |
| 22. I certify that (I) (the hospital) attended the deceased from <b>JAN 21</b> 19 <b>69</b> to <b>JAN 26</b> 19 <b>69</b> , that (I) last saw the deceased alive on <b>JAN 26</b> 19 <b>69</b> and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (the hospital) (did) (did not) view the body after death.          |                         |   |                                    |  |  |                              |  |   |  |  |  |
| 23A. SIGNATURE<br><b>Seymour Levine M.D.</b>   |                         |   |                                    | 23B. DATE SIGNED<br><b>JAN 26, 1969</b>  |  |                              |  |   |  |  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>SEYMOUR LEVINE M.D.</b>   |                         |   |                                    | 23D. ADDRESS<br><b>BALTIMORE CITY HOSPITALS</b><br><b>4940 EASTERN AVE. BALTO. MD. 21224</b>   |  |                              |  |   |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         |   |                                    | 24B. DATE<br><b>1/29/69</b>  |  |                              |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Glen Haven Memorial Park</b>                         |  |  |  |
| 24D. LOCATION<br><b>Glen Burnie, Maryland</b>  |                         |   |                                    |  |  |                              |  |   |  |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 28 1969</b>  |                         |   |                                    | 25B. NAME OF REGISTRAR<br><b>Robert E. Starkey</b>   |  |                              |  | 25C. FUNERAL DIRECTOR<br><b>John J. Duda</b>  |  |  |  |
| 25D. ADDRESS<br><b>7922 Wise Ave. Dundalk, Md</b>  |                         |   |                                    |  |  |                              |  |   |  |  |  |

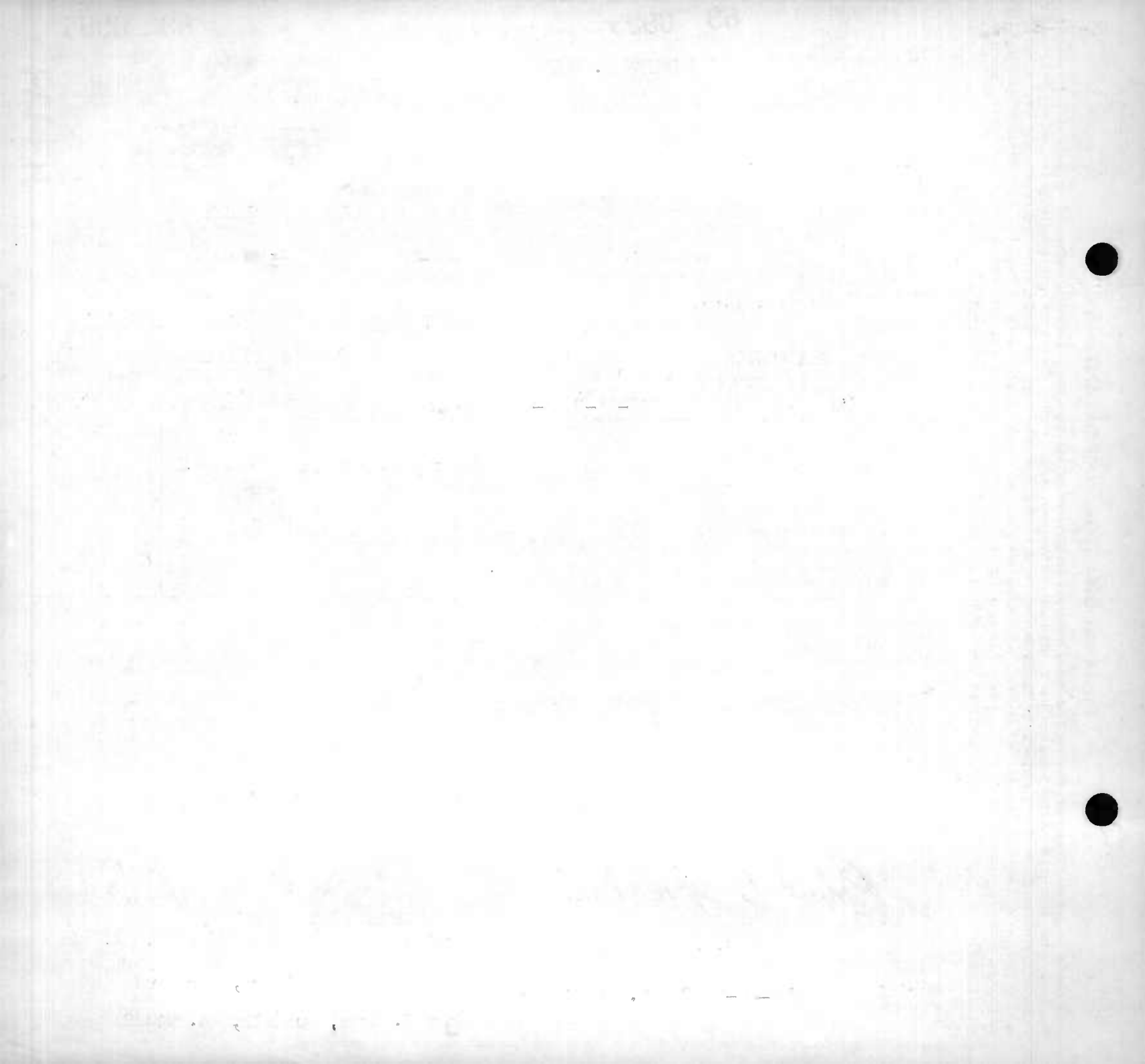


## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                         |   |  |  |   |
|---|-------------------------|---|--|--|---|
| BIRTH NO.   |                         | 1. NAME OF DECEASED<br>(Type or Print) <b>JOSEPHINE R. GETEK</b>  |  | 2. DATE AND HOUR OF DEATH<br><b>JAN. 26, 1969</b>   <b>2:05</b> A.M.   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                         |   |  | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>BALTIMORE CITY HOSPITALS</b><br><b>4940 EASTERN AVENUE</b><br><b>BALTIMORE, MARYLAND 21224</b>  |                         |   |  | C. CITY OR TOWN <b>Dundalk</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |   |
|   |                         |   |  | E. STREET AND NUMBER<br><b>1904 CODD AVENUE 21222</b>  |   |
| 5. SEX<br><b>FEMALE</b>   | 6. RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1-26-04</b>   | 9. AGE (In years last birthday)<br><b>65</b>   | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.         |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                         |   | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                     |
| 13. FATHER'S NAME<br><b>JOSEPH BLACHOWICZ</b>   |                         |   | 14. MOTHER'S MAIDEN NAME<br><b>SOPHIE MIDURA</b>   |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |                         |   | 16. SOCIAL SECURITY NO.<br><b>212-07-0703-A</b>  |  | 17. INFORMANT<br><b>BCH: RECORDS 4940 EASTERN AVE. BALTO. MD.</b> |
| 18. <b>348.0 I</b> CAUSE OF DEATH   |                         |   |  |  |   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)<br><b>ANTecedent CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.             |                         |   | (A) IMMEDIATE CAUSE <b>RESPIRATORY FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) <b>Myotrophic Lateral Sclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____ |  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                         |   |  |  |   |
| 19A. DATE OF OPERATION<br><b>0</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><b>No</b>   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>1/22</b> <b>19 69</b> to <b>1/26</b> <b>19 69</b> , that (I) (we) last saw the deceased alive on <b>1/26</b> <b>19 69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |   |  |  |   |
| 23A. SIGNATURE<br><b>Robert C. Rosenbaum</b>  |                         |   |  | 23B. DATE SIGNED<br><b>1/26/69</b>   |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>ROBERT ROSENBAUM M.D.</b>  |                         |   |  | 23D. ADDRESS<br><b>BALTIMORE CITY HOSPITALS</b><br><b>4940 EASTERN AVENUE BALTO. MD. 21224</b>   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 24B. DATE<br><b>Jan-29-1969</b>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>St. Stanislaus</b>  |   |
| 24D. LOCATION<br><b>Baltimore, Maryland</b>   |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 28 1969</b>   |  |  |   |
| 25B. NAME OF REGISTRAR<br><b>John T. Duda</b>   |                         | 25C. FUNERAL DIRECTOR<br><b>John T. Duda</b>  |  |  |   |
| 25D. ADDRESS<br><b>Dundalk, Md. 21222</b>   |                         |   |  |  |   |







**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. **69 0996**

|  |  |  |  |   |   |
|--|--|--|--|---|---|
| BIRTH NO.  |  | 1. NAME OF DECEASED<br>(Type or Print) <b>Frazier, James RALPH</b>   |  | 2. DATE AND HOUR OF DEATH<br><b>1-23-69 5:25 AM</b>   |   |
| 3. PLACE IN <b>BALTIMORE, MARYLAND</b> , WHERE PRONOUNCED DEAD   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Howard Co</b> |  |   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Franklin Square Hosp</b>  |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |  | C. CITY OR TOWN<br><b>Pessups</b>   | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 5. SEX <b>Male</b>   |  | 6. RACE <b>white</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 8. DATE OF BIRTH<br><b>8-23-16</b>   |  | 9. AGE (In years last birthday) <b>52</b>  |  | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.  |   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Fireman's help</b>   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>BRICK Co</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>  |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 13. FATHER'S NAME<br><b>unknown JAMES FRAZIER</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>unknown MARY FLANNERY</b>  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |  | 16. SOCIAL SECURITY NO.<br><b>228-12-4011</b>  |  | 17. INFORMANT<br><b>Franklin Square Hosp</b>  |   |
| 18. <b>562.1 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>GENERALIZED PERITONITIS</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.<br><b>RUPTURED SIGMOID DIVERTICULUM</b> |  | CAUSE OF DEATH   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |  |  |   |   |
| 19A. DATE OF OPERATION<br><b>22</b>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes) or No   |   |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |  |  |   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                    |  | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>1-22</b> 19 <b>69</b> to <b>1-23</b> 19 <b>69</b> , that (I) (we) lost saw the deceased alive on <b>1-23</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |  |  |  |   |   |
| 23A. SIGNATURE<br><b>Savage Bock hee</b>   |  | DEGREE   |  | 23B. DATE SIGNED<br><b>1-23</b>   |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Savage Bock hee</b>   |  | DEGREE   |  | 23D. ADDRESS<br><b>Franklin Square Hosp</b>   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 24B. DATE<br><b>1/26/69</b>  |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>SAVAGE CEMETERY</b>  |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>SAVAGE, MARYLAND</b>   |  |  |  |   |   |
| 25A. DATE REC'D BY HEALTH DEPT.  |  | 25B. NAME OF REGISTRAR<br><b>JAN 28 1969</b>   |  | 25C. FUNERAL DIRECTOR<br><b>John J. Savage</b>  |   |
| 25D. ADDRESS   |  |  |  |   |   |



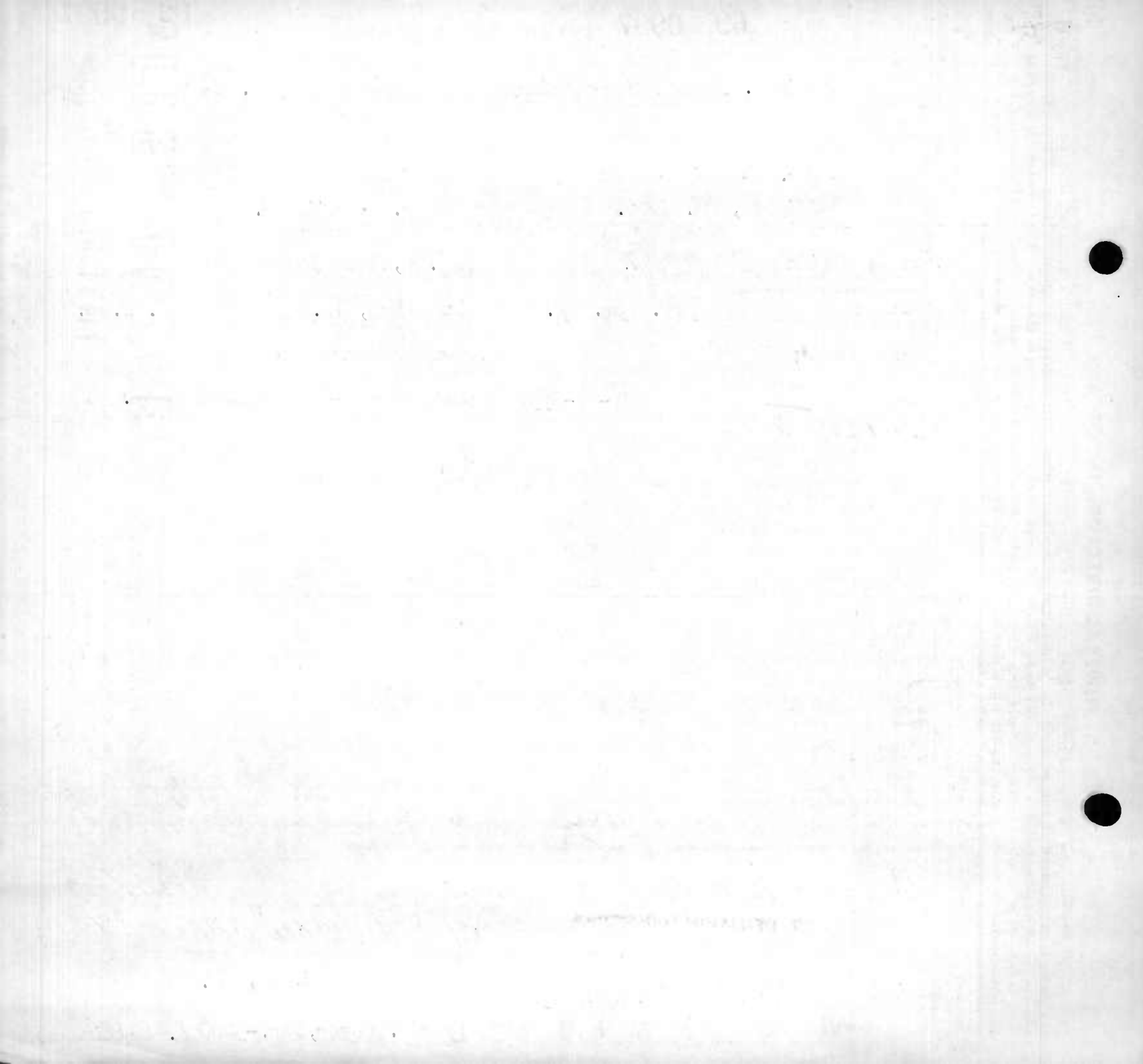
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
69 0997 CERTIFICATE OF DEATH

REG. NO. 69 0997

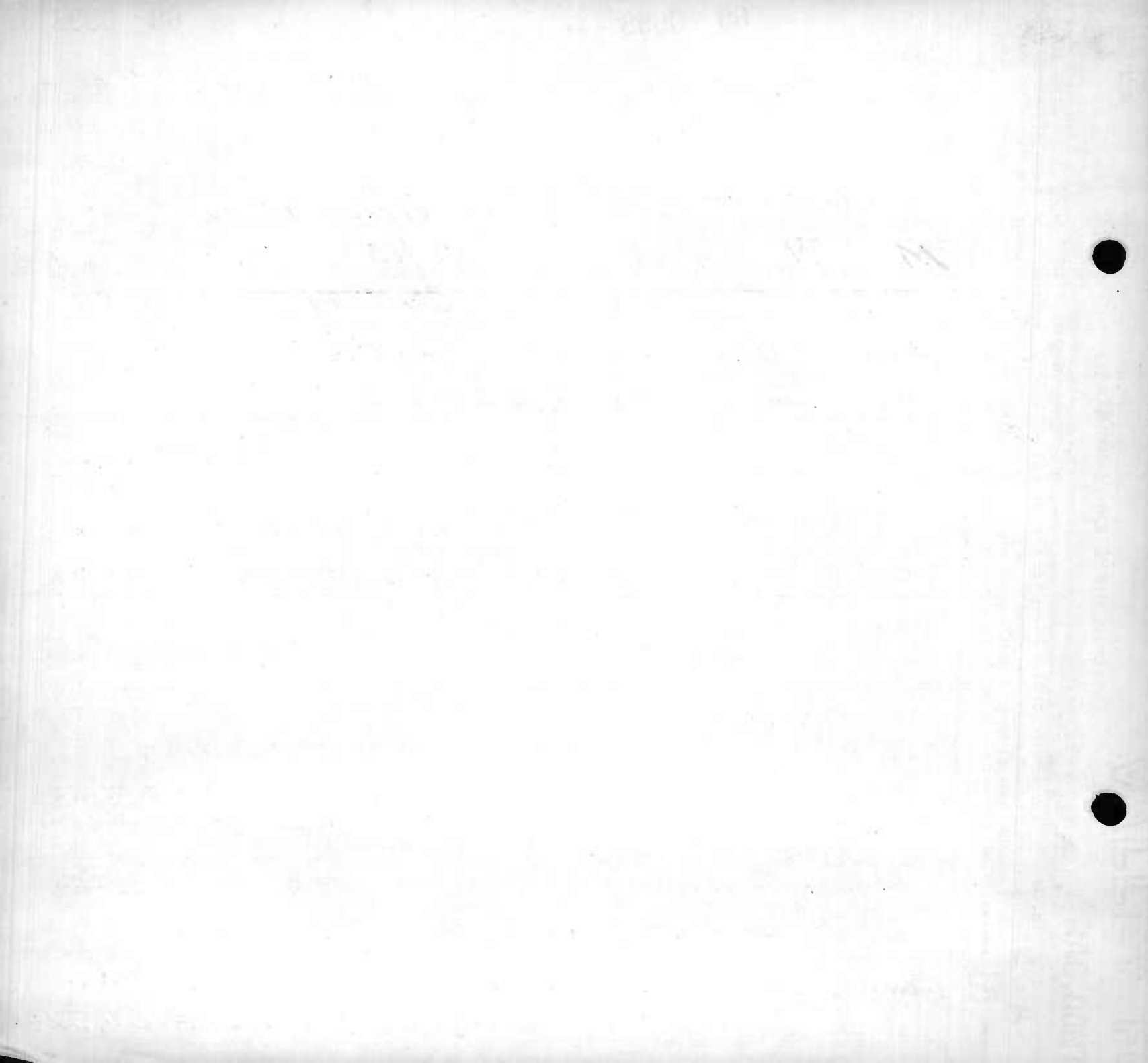
|   |  |   |  |   |  |
|---|--|---|--|---|--|
| BIRTH NO.   |  | 1. NAME OF DECEASED<br>(Type or Print)  |  | 2. DATE AND HOUR OF DEATH   |  |
|   |  | Mamie A. Samuel (nee Petty)   |  | January 25th, 1969 M.   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE<br>B. COUNTY  |  | 26-10   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>00  |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>222 S. Bouldin Street<br>Baltimore, Md. 21224.                                  |  | C. CITY OR TOWN<br>Baltimore<br>D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |  |
| 5. SEX<br>Female  |  | 6. RACE<br>White  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 9. AGE (In years last birthday)<br>Aug. 24, 1892 76   |  |
| Inspector   |  | Cont. Can. Co.  |  | 11. BIRTHPLACE (State or foreign country)<br>Alexandria, Va.  |  |
| 13. FATHER'S NAME<br>Edward Petty   |  | 14. MOTHER'S MAIDEN NAME<br>Mary Walker   |  | 12. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  |
| 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br>No   |  | 16. SOCIAL SECURITY NO.<br>219-12-7557  |  | 17. INFORMANT<br>Melvin Samuel-4101 Eastmont Ave.   |  |
| 18. 412.4 + 258.9<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>A.S.C.V.D.I.S.<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) _____<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 YRS  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |  | DIABETES  |  | 5 YRS   |  |
| 19A. DATE OF OPERATION  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)   |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 5/29/69 to 1/25/69, that (I) (we) last saw the deceased alive on 1/22/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |  |   |  |   |  |
| 23A. SIGNATURE<br>Benjamin Hochstet   |  | 23B. DATE SIGNED<br>1/27/69   |  | 23C. PHYSICIAN'S NAME (Type)<br>DR. BENJAMIN HOCHSTET   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |  | 24B. DATE<br>1/28/69  |  | 24C. NAME of CEMETERY or CREMATORY<br>Oak Lawn Cemetery   |  |
| 24D. LOCATION<br>Baltimore, Md.   |  | 24E. NAME of REGISTRAR<br>John A. Mohan, Inc.   |  | 24F. FUNERAL DIRECTOR<br>3000 E. Baltimore St.  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>JAN 28 1969  |  | 25B. NAME OF REGISTRAR  |  | 25C. FUNERAL DIRECTOR   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO.   |         | BALTIMORE CITY HEALTH DEPARTMENT   |                  | REG. NO.   |                              |
|---|---------|--|------------------|--|------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print)  |         | 2. DATE AND HOUR OF DEATH  |                  |  |                              |
| August E. Hoer  |         | 24 January 1969 1:00 A.M.  |                  |  |                              |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |         | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  |                  |  |                              |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |         | A. STATE<br>B. COUNTY  |                  |  |                              |
| 34 Bon Secours Hospital   |         | Maryland Balto.  |                  | 53-00  |                              |
|   |         | C. CITY OR TOWN  |                  | D. INSIDE CITY LIMITS?   |                              |
|   |         | BALTIMORE  |                  | YES <input type="checkbox"/> NO <input type="checkbox"/>                 |                              |
|   |         | E. STREET AND NUMBER   |                  |  |                              |
|   |         | 227 BLAKENEY ROAD  |                  |  |                              |
| 5. SEX  | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   | 8. DATE OF BIRTH | 9. AGE (In years lost birthday)  | 10. CITIZEN OF WHAT COUNTRY? |
| M   | W       | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 1/5/83           | 85   | U.S.A.                       |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |         | 10B. KIND OF BUSINESS OR INDUSTRY  |                  | 11. BIRTHPLACE (State or foreign country)                                |                              |
| Brewer  |         | Globe Brewery  |                  | Germany  |                              |
| 13. FATHER'S NAME   |         | 14. MOTHER'S MAIDEN NAME   |                  |  |                              |
| August Hoer   |         | NOT KNOWN  |                  |  |                              |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |         | 16. SOCIAL SECURITY NO.  |                  | 17. INFORMANT  |                              |
| No  |         | 214-01-9424  |                  | Pts. CHART   |                              |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |         | CAUSE OF DEATH   |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |                              |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  |         | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  |                  | Pneumonia @ LUNG   |                              |
| ANTECEDENT CAUSES   |         | (B) DUE TO, OR AS A CONSEQUENCE OF:  |                  | DIABETES MELLITUS  |                              |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |         | (C) DUE TO, OR AS A CONSEQUENCE OF:  |                  | MYOCARDIAL DISEASE   |                              |
| II  |         | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |                  |  |                              |
| 19A. DATE OF OPERATION  |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                  | 20A. AUTOPSY? (Yes or No)  |                              |
|   |         |  |                  |  |                              |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                              |
|   |         |  |                  |  |                              |
| 21D. TIME OF INJURY (APPROX.)   |         | 21E. INJURY OCCURRED   |                  | 21F. HOW DID INJURY OCCUR?   |                              |
|   |         | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                  |  |                              |
| 22. I certify that (I) (this hospital) attended the deceased from 1-10-1969 to 1-24-1969, that (I) (we) last saw the deceased alive on 1-24-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |  |                  |  |                              |
| 23A. SIGNATURE  |         |  |                  | 23B. DATE SIGNED   |                              |
| Shawney Onkasowan M.D.  |         |  |                  | 1-24-69  |                              |
| 23C. PHYSICIAN'S NAME (Type)  |         |  |                  | 23D. ADDRESS   |                              |
| CHARWEN ONKASOWAN M.D.  |         |  |                  | BON SECOURS HOSPITAL   |                              |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |         | 24B. DATE  |                  | 24C. NAME OF CEMETERY or CREMATORY                                       |                              |
| Burial  |         | 1-27-69  |                  | London Park Cm.  |                              |
|   |         |  |                  | Baltimore Md.  |                              |
| 25A. DATE REC'D BY HEALTH DEPT.   |         | 25B. NAME OF REGISTRAR   |                  | 25C. FUNERAL DIRECTOR  |                              |
| JAN 28 1969   |         | R. J. J. J. J.   |                  | D. J. J. J. J.   |                              |
|   |         |  |                  | ADDRESS  |                              |



D-400

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |  |   |  |
|--|--|---|--|
| BIRTH NO.  |  | REG. NO.  |  |
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>HERBERT DULL</b>  |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month Day Year Hour<br><b>January 25, 1969</b> M. |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>South Baltimore General Hospital (DOA)</b>  |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>January 25, 1969 9:40 A.M.</b>   |  |
| 6. SEX<br><b>Male</b>  |  | 7. RACE<br><b>White</b>   |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>24-04</b>           |  |
| 9. DATE OF BIRTH<br><b>May 24, 1920</b>  |  | 10. AGE (In years last birthday)<br><b>48</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Balto. Md.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Ukn.</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Ukn.</b>   |  |
| 15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>   |  | 16. KIND OF BUSINESS OR INDUSTRY<br><b>Balto. City</b>  |  |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes WWII</b>   |  | 18. SOCIAL SECURITY NO.   |  |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Bronchopneumonia</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Arteriosclerotic cardiovascular disease</b>  |  | 20. IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(A) <b>Bronchopneumonia</b><br>(B)<br>(C)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>Arteriosclerotic cardiovascular disease</b>   |  |   |  |
| 22A. DATE OF OPERATION<br><b>2</b>   |  | 22B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 22C. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 22D. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| 22E. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)   |  | 22F. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |
| 22G. HOW DID INJURY OCCUR?   |  | 22H. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?  |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED <b>January 27, 1969</b> |  |   |  |
| ACTUAL SIGNATURE<br><b>Charles S. Springate, M.D.</b>  |  | EXAMINER'S NAME (Type)<br><b>Charles S. Springate, M.D.</b>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>1-29-69</b>   |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Balto. Natl. Cem.</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b>  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 28 1969</b>  |  | 25B. NAME OF REGISTRAR<br><b>Robert S. Fabela</b>   |  |
| 25C. FUNERAL DIRECTOR<br><b>McSully</b>  |  | ADDRESS<br><b>130 E. Fort Ave Balto. Md. 21230</b>  |  |



Attest:

By:

John H. Smith

John H. Smith

John H. Smith

John H. Smith

John H. Smith

John H. Smith

John H. Smith

John H. Smith

John H. Smith

John H. Smith



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 1000

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 69 1000

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| BIRTH NO.  |  | 1. NAME OF DECEASED<br>(Type or Print) <b>MRS. ROSAMOND MAHONEY (MARGARET)</b>                                       |  | 2. DATE AND HOUR OF DEATH<br><b>1-23-69 7 AM</b>  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                |  | M. <b>20-08</b>   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>34 Bon Secour Hospital<br/>FAYETTE + PULASKI ST.</b>  |  | A. STATE<br><b>MD.</b>   |  | B. COUNTY<br><b>BALTO.</b>  |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |  | C. CITY OR TOWN<br><b>BALTO.</b>   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                         |  |
| 5. SEX<br><b>F</b>   |  | 6. RACE<br><b>W</b>  |  | E. STREET AND NUMBER<br><b>214 S. AUGUSTA AVE.</b>  |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><b>3-1-09</b>  |  | 9. AGE (In years lost birthday)<br><b>60 59</b>   |  |
| WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>AIDE (HOSPITAL)</b> |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Nicholas Weber</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>FRYFOGLE - Gertrude</b>   |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b> |  |
| 16. SOCIAL SECURITY NO.<br><b>217-12-8831</b>  |  | 17. INFORMANT<br><b>MR. William F. Mahoney</b>   |  | ADDRESS (29)<br><b>214 S. Augusta Ave.</b>  |  |
| 18. <b>5-19-1 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>pulmonary edema</b>  |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>acute-pul. edema</b>                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 AM - 7 AM</b>  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  | (B) DUE TO, OR AS A CONSEQUENCE OF:  |  | (C) DUE TO, OR AS A CONSEQUENCE OF:   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |  |  |   |  |
| 19A. DATE OF OPERATION<br><b>0</b>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                             |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>            |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>12-13-1968</b> to <b>1-23-1969</b> , that (I) (we) last saw the deceased alive on <b>1-23-1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |   |  |
| 23A. SIGNATURE<br><b>H. MAKIPOUR</b>   |  | DEGREE<br><b>H. MAKIPOUR</b>   |  | 23B. DATE SIGNED  |  |
| 23C. PHYSICIAN'S NAME (Type)   |  | 23D. ADDRESS   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>1/27/69</b>  |  | 24C. NAME of CEMETERY or CREMATORY<br><b>MT. Olive Cem.</b>   |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>RANDALLSTOWN, Md.</b>  |  | 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 28 1969</b>  |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor</b>   |  |
| 25C. FUNERAL DIRECTOR<br><b>G. T. ...</b>  |  | ADDRESS (29)<br><b>3512 Fred. Ave.</b>   |  |   |  |

